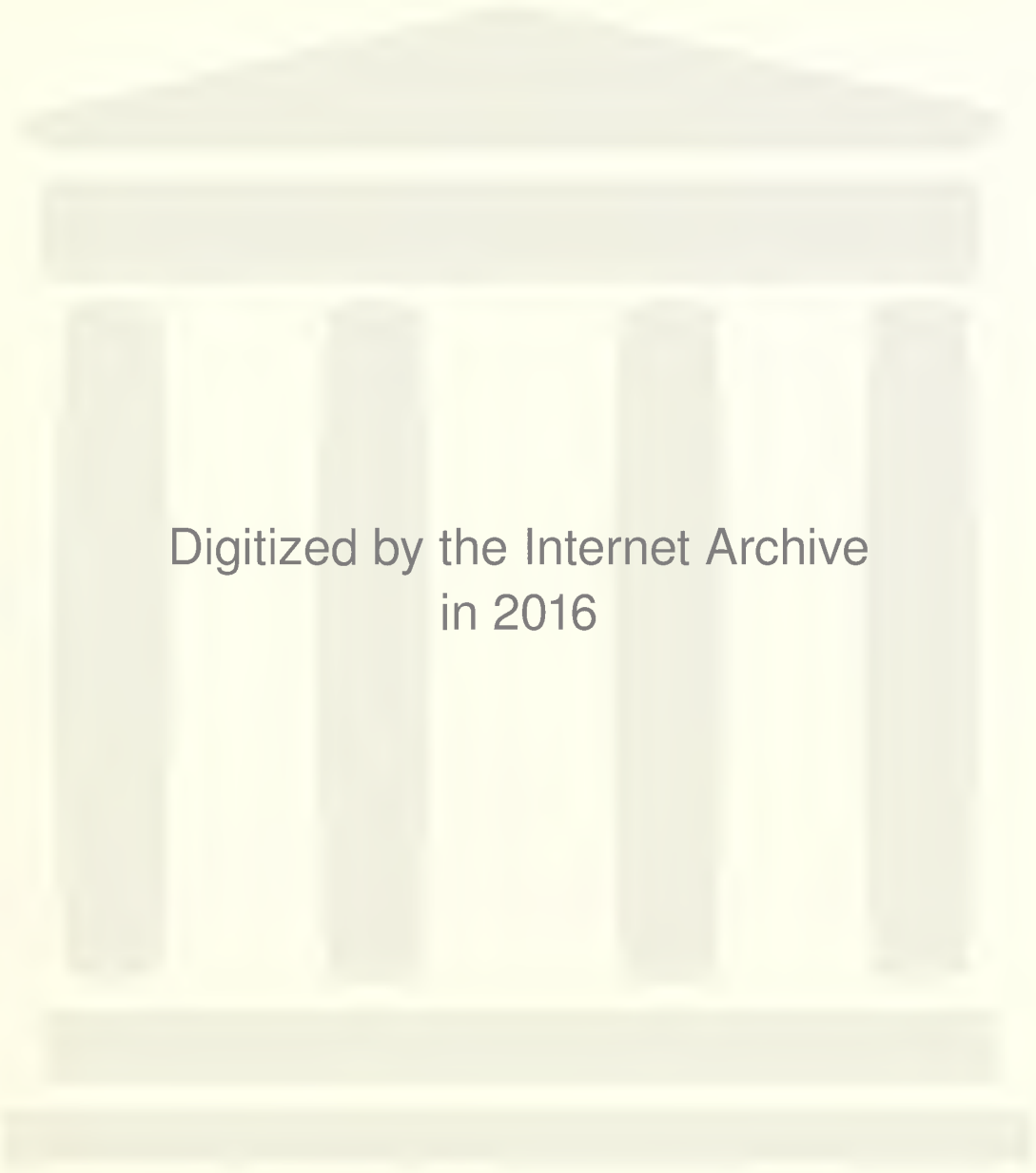
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Rhode Island Medical Journal

January 1986
Volume 69, Number 1



A Cambodian interpreter at Rhode Island Hospital — See page 11

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THE FRANCIS A. COUNTWAY
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BOSTON, MA
JAN 23 1986

Newsletter

RHODE ISLAND MEDICAL SOCIETY
January 1986

Herbert Rakatansky, MD, President
Wendy J. Smith, Editor

ALL DOCTORS SHOULD JOIN RIMS, SOCIETY RECOMMENDS

The Society will recommend to the General Assembly that all physicians be required to join the Rhode Island Medical Society so that they are subject to the peer review activity of the Society. RIMS also will seek authority for the Board of Medical Review, the state disciplinary agency, to refer cases to the Society for review.

The actions were part of a ten-point legislative package designed to alleviate the malpractice crisis. Other components include:

- Mandated qualifications for expert witnesses.
- Elimination of the collateral source rule to avoid duplicate payments.
- A cap on prejudgment interest at a rate tied to the Consumer Price Index.
- No awards for "pain and suffering."
- A sliding scale for attorneys' fees.
- A special statute of limitation for minors providing that a child under age six who incurs an injury has until his ninth birthday to file suit.
- A cap on individual physician liability at $500,000.

In other actions at its December 2 meeting, the Council also:

- received a report that certificate-of-need limits for the state will be raised over a three year period to $250,000 for services, $400,000 for equipment, and $600,000 for capital expenditures.
- approved a new membership application.
- noted that discussions currently are

COUNCIL MEETS (continued)

under way with Health Care Review, Inc, the professional review organization for the state, to permit the referral of problem cases to the Peer Review Committee on Physician Competency. Because Health Care Review is prohibited by federal regulation from disclosing information about incompetent physicians, all problem cases are referred to the Inspector General of the Department of Health and Human Services. Under a proposal drafted by the Society, the affected physician would have the option of having Medicare denials reviewed by the RIMS committee instead of the Inspector General.

- voted to defray the expenses of two medical students in attending the AMA Interim Meeting, December 8-11, 1985, Washington DC. The students will report at the January 1986 meeting of the RIMS House of Delegates.
- approved recommending to New England Telephone Company that the Yellow Page listing of allopathic and osteopathic physicians be integrated with a designation of the physician's degree after each entry. There currently are two separate categories, "physicians-MDs" and "physicians-DOs."
- recommended to the House of Delegates that dues-exempt status be extended to physicians under age 70 who have retired from active practice. Dues-exempt status currently is available only to members over age 70 upon written request. All dues-exempt members, however, will be encouraged to make a contribution to the Society.
- endorsed the disability income insurance proposal offered by the New England Life Insurance Company.
- recommended that the Society offer its members the opportunity to enroll in

COUNCIL MEETS (continued)

Ocean State Physicians' Health Plan, Rhode Island Group Health Association, and other HMOs in addition to the current coverage available from Blue Cross & Blue Shield of Rhode Island.

- approved the Uniform Rights of the Terminally Ill Act. Developed by the National Conference of Comissioners on Uniform State Laws, the bill would establish a living will mechanism for Rhode Island. Previous attempts to enact living will legislation have been unsuccessful because of the opposition of the Providence Diocese.

- recommended to the House of Delegates that it approve the interprofessional code of professional relations between physicians and attorneys. Developed by a joint RIMS/Rhode Island Bar Association Committee, the code represents two years of work and covers such matters as medical reports, depositions, and court testimony.

RIMS MEETS WITH MARYLAND OFFICIALS

President Dr Herbert Rakatansky and RIMS staff met December 5 with officials of the Medical and Chirurgical Faculty of Maryland, the Maryland Disciplinary Board, and the University of Maryland Medical School to discuss an arrangement under which the Maryland medical society functions as the investigatory arm for the state's medical review board. The medical society also has an agreement with the University of Maryland Medical School to provide for the reeducation of incompetent physicians who are uncovered by the Board.

A multi-pronged approach to strengthen the peer review functions of state medical societies is taking place both in Rhode Island and across the country. Part of the Rhode Island Medical Society's ten-point legislative package to alleviate the malpractice crisis includes a proposal to provide a formal agreement between the Society and the Board of Medical Review for the rehabilitation of physicians whose practices do not meet acceptable standards (see also page 1). Moreover, the AMA has developed two model state

PEER REVIEW (continued)

bills which would strengthen the status of peer review committees. One bill provides for an agreement between medical societies and state medical review boards permitting the societies to undertake review activities. A second bill states that charging an excessive fee is considered "unprofessional conduct" subject to state disciplinary action. Because physicians who charge excessive fees would be subject to state disciplinary action, the bill would have the effect of allowing medical societies to review fees for the state.

At the federal level, the AMA's Model National Professional Liability Reform Act, sponsored by Senator Orrin Hatch (R, Utah), would require state and county medical societies to investigate allegations of professional misconduct.

MASSACHUSETTS REQUIRES MEDICARE ASSIGNMENT

The Commonwealth of Massachusetts recently enacted a law requiring that as a condition of granting or renewing a license to practice medicine, a physician must agree to accept the Medicare assignment as payment in full for treating Medicare beneficaries. The constitutionality of the law is being challenged in a lawsuit recently filed by the American Medical Association and the Massachusetts Medical Society.

In a letter to Massachusetts Governor Michael S. Dukakis, RIMS President Dr Herbert Rakatansky said, "we oppose any law or regulation that would tie licensure for any profession to anything other than professional competence."

MOVE TO ACCRUAL ACCOUNTING REJECTED

A panel of the US House Ways and Means Committee concentrating on accounting issues in the tax reform package has decided to exempt such professionals as physicians, accountants, lawyers, and architects from a provision requiring businesses with annual gross receipts of more than $5 million to use the accrual method of accounting rather than the cash method. The decisions of the working panels generally are accepted by the full Ways and Means Committee.

ACCRUAL ACCOUNTING (continued)

The action is responsive to concerns raised by the American Medical Association and other organizations representing professionals. In statements to the tax-writing committees of Congress, the AMA indicated its strong opposition to the proposed elimination of the cash method of accounting for all businesses with gross receipts of more than $5 million. The Association pointed out that this proposal would have a negative impact on a significant number of physicians.

RI PHYSICIANS HEAR ABOUT UNIONS

More than 150 members packed the Medical Society Auditorium on December 3 to hear the president of a fledgling doctors' union in Massachusetts tell them that unionization, especially in the wake of soaring malpractice premiums and fee limits, is needed to "put the physician back into the equation of health care."

That assessment, by Dr John T. LaRossa, president of the newly-formed Physicians and Surgeons Association of Massachusetts, was disputed by Dr Robert Macafee of Portland, Maine, a trustee of the American Medical Association. Macafee, while agreeing on the problems currently facing physicians, contended that existing medical societies can serve their needs adequately. LaRossa, a Newton, Massachusetts internist, said more than six per cent of the state's physicians have joined his union since its formation four months ago. Third-party payers, he claimed, have indicated a willingness to negotiate with the group.

Macafee said that existing organizations,

UNIONS (continued)

such as his local medical society and the American Medical Association, have represented him well. Physicians are suffering from the "demythology of medicine," Macafeee said. The patient has become more sophisticated and medicine over the past two decades has changed from a "cottage industry" to a corporate mentality.

Also addressing the group was Ruay Lahy, a labor lawyer who helped organize the Massachusetts physicians' union. She told the audience that the time has come for physicians to use the laws that allow them to organize a union for collective bargaining "to the advantage of themselves and health care."

TORT REFORM WOULD SAVE DOLLARS

Additional justification for significant tort reform was provided through the recent release of an AMA-commissioned actuarial study showing that tort reform could save physicians nearly $1 billion in professional liability insurance premiums in 1986 alone. The study was prepared by the actuarial firm of Milliman and Robertson, Inc of New York.

The study indicated that a state may realize savings from each of the recommended tort reforms as follows: periodic payment of settlements and awards - 6 per cent; elimination of collateral source rule to avoid duplicate payment - 8 per cent; limitation on non-economic damages to $250,000 - 12 per cent; and limitation on attorneys' contingency fees - 9 per cent. The total potential savings for a state would be 28 per cent.

PRACTICE MANAGEMENT QUESTION OF THE MONTH:

MARKETING YOUR PRACTICE

As hospitals and HMOs increase their promotional activities, group practices and solo practioners will be left behind if they do not take steps to make their services known to the public. A multi-faceted approach that combines a variety of media and techniques, including advertising, personal selling, and publicity, is the most effective. There are a number of techniques that group practices can use to promote use of their services by establishing a separate identity:

Develop a logo: Every charity and corporation is aware of the need for a symbol that easily identifies it to the public. To be effective, a logo must be significant, descriptive of the organization, distinctive, and enduring. If your practice is developing a logo, your attorney should check it to make sure that it has not already been registered by another organization. Assistance in developing a logo can be obtained from a specialist in an art and design firm or the art department of an advertising agency.

Brochures: Every medical practice should publish a patient handbook that describes services offered, the backgrounds and qualifications of professional staff, and special services provided, as well as administrative information such as the appointment system, fees, billing, credit availability, arrangements for after-hours consultation, and so forth. A patient handbook can eliminate numerous questions and facilitate administrative handling.

Educational brochures on common medical problems, such as allergies, lower back pain, or birth control, will provide a valuable service to patients. In developing printed materials, it is important to be sensitive to hidden messages. Because the emphasis of a health maintenance organization is on health maintenance, for example, many HMOs are careful to portray only healthy persons in their promotional literature.

Newsletter: A patient newsletter is effective in promoting loyalty among existing patients, acquainting them with practice staff, and providing information on services and procedures. Since publishing a newsletter can be costly and time-consuming, one alternative is distribution of a purchased newsletter. The Medical Group Management Association has developed Health Matters, a quarterly newsletter on health promotion, at bulk subscription rates. Subscribers ordering more than 5,000 copies can have the group's masthead or logo printed and prepare a column containing information on their own group. For additional information, write the Center for Research, 1344 South Colorado Boulevard, Suite 900, Denver, Colorado 80222.

Publicity is unpaid media coverage. To be successful, publicity should be carefully planned and implemented by the practice itself. Publicity is a good promotional tool for medical practices, since it is low cost and avoids the appearance of selling.

Public appearances: Public appearances by medical staff are an excellent way of gaining visibility for a practice and communicating expertise. Speeches to professional peers about current research or techniques can be an effective way for specialty practices to generate referrals. Speeches on specific conditions to appropriate community groups can be a good method of attracting new patients.

News releases: News releases are an effective means of publicizing a newsworthy event, such as opening of a new facility or a satelite office, hiring of new professional staff, participation in public service activities, or a public appearance by a staff member.

In preparing news releases, it is important to ascertain deadlines since many newspapers and radio and television stations require several days advance notice. The name of an appropriate contact person and his or her telephone number must be included for reporters to call for additional information.

Freebies: Offering free physical examinations to selected groups is a good way of introducing new patients to your practice and generating goodwill. Some physicians offer free pre-employment physical examinations, examinations for school athletes, or yearly examinations for local police or firefighters. Free screening at health fairs is another way of introducing your staff to the area.

SEMI-ANNUAL CALENDAR OF CONTINUING MEDICAL EDUCATION EVENTS

NOTE: Lectures and courses are listed by the date, sponsor, topic, speaker, and telephone number for additional information. Please call the contact number for specific information about the program.

JANUARY

2 The Miriam Hospital, "Cytoprotection of the Gastrointestinal Tract," Fred Gorelick, MD, 274-3700, ext. 4000

13 Roger Williams General Hospital, "Vascular Conference," 456-2459

13 General Hospital-RIMC, "Psychogeriatric Case Presentation," 464-3493

13 General Hospital-RIMC, "Peripheral Neuropathies in the Elderly," Stanley M. Aronson, MD, 464-3493

16 The Miriam Hospital, "Pick's Disease and other Atypical Dementias," Michael Alexander, MD, 274-3700, ext. 4000

16 General Hospital-RIMC, "Clinical Pathological Conference," 464-3493

24 General Hospital-RIMC, "Electrolyte Imbalance in the Elderly," R. Solomon, MD, 464-3493

29 Roger Williams General Hospital, "Otorhinolaryngology Conference," 456-2460

30 The Miriam Hospital, To be announced, C. Ronald Kahn, MD, 274-3700

FEBRUARY

10 Roger Williams General Hospital, "Vascular Conference," 456-2459

10 General Hospital-RIMC, "Management of Infectious Diseases in the Elderly," D. Craven, MD, 464-3493

11 General Hospital-RIMC, "Psychogeriatric Case Presentation," 464-3493

20 General Hospital-RIMC, "Clinical Pathological Conference," 464-3493

24 General Hospital-RIMC, "The Effect of Dietary Deficiencies on the Nervous System in the Elderly," Stanley M. Aronson, MD, 464-3493

27 The Miriam Hospital, "Delta Hepatitis," Jules Dienstag, MD, 274-3700, ext. 4000

MARCH

6 The Miriam Hospital, "Cell-Cell Interactions in the Adult Respiratory Distress Syndrome," Jean E. Rinaldo, MD, 274-3700, ext. 4000

MARCH

7	The Memorial Hospital, Kenney Day Program, 722-6000, ext. 2142
10	Roger Williams General Hospital, "Vascular Conference," 456-2460
10	General Hospital-RIMC, "Epidemiology and Pathophysiology of Diseases of Vision and Hearing in the Aged," Stanley M. Aronson, MD, 464-3493
11	General Hospital-RIMC, "Psychogeriatric Case Presentation," 464-3493
12	Roger Williams General Hospital, "Inspiratory Muscle Fatigue and Response Failure," Peter Macklem, MD, 456-2070
12	The Miriam Hospital, "Radiology of Polycystic Kidney Disease," Harry Mellins, MD, 274-3700, ext. 4000
20	General Hospital-RIMC, "Clinical Pathological Conference," 464-3493
26	Roger Williams General Hospital, "Otorhinolaryngology Conference," 456-2460
27	The Miriam Hospital, "Clinical Aspects of ADH Physiology," Janet Amico, MD, 274-3700, ext. 4000

APRIL

3	Roger Williams General Hospital, "Coagulopathies," William Williams, MD, 456-2070
3	The Miriam Hospital, "Coagulopathies," William Williams, MD, 274-3700
8	General Hospital-RIMC, "Psychogeriatric Case Presentation," 464-3493
14	Roger Williams General Hospital, "Vascular Conference," 456-2460
17	The Miriam Hospital, "Laser Applications in Ischemic Heart Disease," Martin Leon, MD, 274-3700, ext. 4000
17	General Hospital-RIMC, "Neoplasms of the Central Nervous System in the Elderly Population," Stanley M. Aronson, MD, 464-3493
17	General Hospital-RIMC, "Clinical Pathological Conference," 464-3493
24	The Miriam Hospital, "Is Atherosclerosis Reversible?" Thomas Clarkson, DVM, 274-3700, ext. 4000

MAY

5	General Hospital-RIMC, "Clinical Features and Pathology of Head Injury," Stanley M. Aronson, MD, 464-3493
8	The Miriam Hospital, To be announced, Bernard Forget, MD, 274-3700

MAY

12	Roger Williams General Hospital, "Vascular Conference," 456-2460
13	General Hospital-RIMC, "Psychogeriatric Case Presentation," 464-3493
14	The Miriam Hospital, "Ethical Aspects of Journal Article Review and Publication," Thomas Stossel, MD, 274-3700, ext. 4000
15	General Hospital-RIMC, "Clinical Pathological Conference," 464-3493
22	The Miriam Hospital, To be announced, Jeremy Ruskin, MD, 274-3700
28	Roger Williams General Hospital, "Otorhinolaryngology Conference," 456-2460

JUNE

5	The Miriam Hospital, "New Approaches to the Diagnosis and Treatment of Non-Hodkin Lymphomas," Lee Nadler, MD, 274-3700, ext. 4000
9	Roger Williams General Hospital, "Vascular Conference," 456-2460
19	General Hospital-RIMC, "Clinical Pathological Conference," 464-3493

CONTINUING SERIES

Butler Hospital (456-3726)

Tuesday	10:30 am	Psychiatrist-in-Chief Rounds
Wednesday	11:00 am	Neuropsychiatric Rounds
Thursday	10:30 am	Academic Grand Rounds in Psychiatry (January 16, February 20, March 19, April 17, May 15, and June 19)
1st Thursday	10:30 am	Chairman's Case Conference

The Memorial Hospital, Pawtucket (722-6000, ext. 2142)

Daily (except Wednesdays)	10:15 am	Radiology Conference
Monday	12:15 pm	Medicine/Family Medicine Core Curriculum
Tuesday	8:30 am	Cardiology Conference
Tuesday	8:00 am	Hematology/Oncology Conference (except last Tuesday of month)
Last Tuesday	7:30 am	Tumor Board Conference
Wednesday	8:00 am	Pediatric Grand Rounds
Wednesday	10:00 am	Medical Grand Rounds
Alternating Wednesdays	12:15 pm	Pulmonary Case Review
Wednesday	3:00 pm	Pathology Conference

The Memorial Hospital, Pawtucket (722-6000, ext. 2142)

Alternating Wednesdays	12:15 pm	Infectious Disease Committee
Thursday	12:00 pm	Family Practice Grand Rounds
Thursday	8:00 am	Surgical Grand Rounds
Thursday	8:00 am	Orthopedic Conference
Thursday	8:00 am	OB/GYN Conference
Thursday	4:30 pm	Surgical Service Conference (Morbidity/ Mortality)

Roger Williams General Hospital (456-2460)

Wednesday	7:30 am	Surgical Conference
Last Wednesday	7:30 am	Morbidity/Mortality Conference
1st and 3rd Wednesdays	7:30 am	Orthopedic Conference
Wednesday	8:00 am	Anesthesia Conference
Wednesday	8:00 am	Combined Hospital Pulmonary/Critical Care Grand Rounds
Friday	8:00 am	Urology Conference
Friday	8:30 am	Rheumatology Grand Rounds

Women & Infants Hospital (274-1100, ext. 1588)

Tuesday	7:30 am	Department of Obstetrics and Gynecology Tumor Board
Wednesday	7:45 am	Perinatal Management Conference
1st, 4th, and 5th Saturdays	9:00 am	Department of Obstetrics and Gynecology Guest Lecturer
2nd Saturday	9:00 am	Journal Club
3rd Saturday	9:00 am	Complications Lecture

Rhode Island Medical Journal

January 1986
Volume 69, Number 1

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Cover:

Manavy Rim Lay helps Penh Yang communicate with Doctor Gregory Ball in the Medical Clinic of Rhode Island Hospital. Meeting the communication needs of the Southeast Asian community is one of the goals of the Indochinese Action Group. See page 29.

Photograph courtesy of Rhode Island Hospital.

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A WORD TO THE WHYS

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WHY AMA? Now, for the first time there's a forum for hospital medical staffs to meet nationally to discuss common problems and changes in physician-hospital relationships. The Hospital Medical Staff Section was recently created by the AMA to provide leadership in ensuring quality patient care during this period of massive hospital restructuring. It's one more good reason why you should be a part of the AMA.

WHY AMA? Commitment to maintaining high quality at all levels of medical education is one of the AMA's proudest traditions. The AMA creates policy for medical education, participates in accreditation activities, and supplies the public with information on medical education issues. Proven dedication to high standards in medical education: it's one more good reason why you should be a part of the AMA.

To Join, Contact your county or state medical society or write: Division of Membership, AMA, 535 North Dearborn Street, Chicago, Illinois 60610 or call collect, (312) 751-6196.

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EDITORIAL

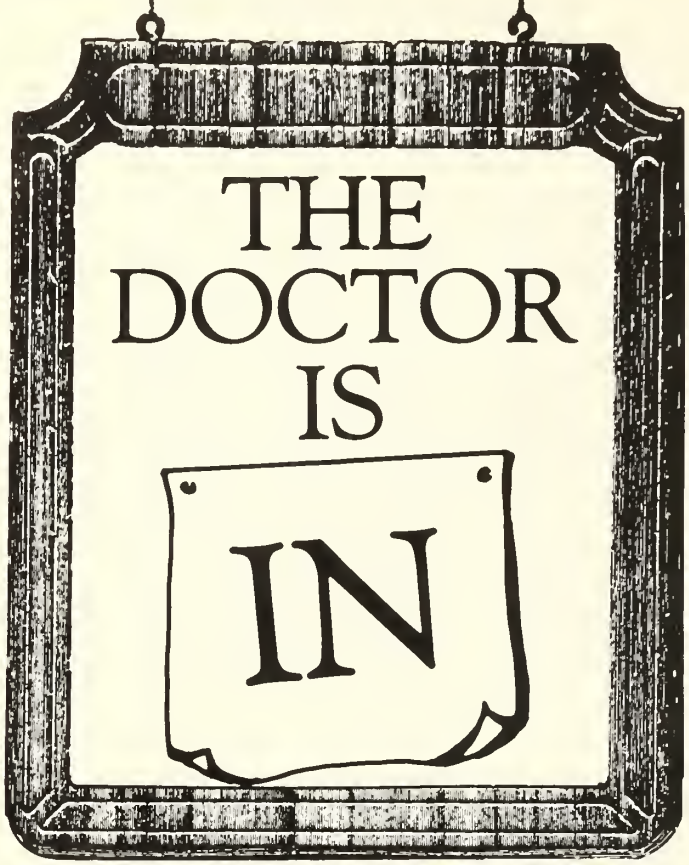
Caring

There is an aspect of the malpractice crisis beyond an inequitable tort system, a litigious society, greedy lawyers, and careless or incompetent physicians. All of these are relevant and to some extent contributing factors, but a very important element is too often left out of the equation — a caring physician.

In observing the scene for more than half a century, this writer has seen a significant, if not universal, change in the behavior of physicians and medical personnel. Too often physicians have become technicians devoid of any semblance of the old-fashioned bedside manner. A sick patient brought to the emergency room is treated summarily by faceless bureaucrats, more intent on recording the data than on comforting the patient. The patient is often told little of what is going on. Relatives accompanying the patient are treated as intruders. The atmosphere is more like that of a police station than a haven for the ill. Dispositions are referred to the social science department as one might order a urine or blood count. The physician is frequently too busy, too preoccupied, or too disinterested to become involved in consulting with the family and social service in arriving at a solution best suited to the patient's needs. Residents in large hospitals too seldom have the opportunity or too frequently are urged by the full-time academic faculty to learn the true needs of a patient beyond a Swan-Ganz catheter or the blood pH. The specialist who treats the patient may be once or twice removed from the family background or the patient's fears and problems. The mechanical listing of possible complications to satisfy the requirements of informed consent can be a litany of possible disasters rather than an exercise in communication. The doctor in his office too often appears hurried, busy and disinterested in his patients.

These are some, but by no means all, of the things that create the impression of not caring. Just as medical schools and hospitals have at long last turned their attention to learning the significance of the high cost of medical care, they must now turn their attention to inculcating in medical students, nurses, and hospital personnel a cult of caring. This, more than public relations or tort reform, will further the alleviation of the malpractice crisis.

Seebert J. Goldowsky, MD



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PRESIDENT'S PAGE

AMA Interim Meeting — 1985

Recently a number of friends joined the AMA at my urging. Upon returning from the recent interim meeting of the AMA House of Delegates, I wrote a letter to each of them telling of some of the highlights of the meeting. Although a complete report of the AMA meeting will be available later, I think it appropriate that every member of the Rhode Island Medical Society should have the opportunity to read this also:

Dear Doctor:
Since you have recently joined the AMA at my urging, I thought it would be appropriate to drop you a personal note and let you know some of what transpired at the recent meeting of the AMA House of Delegates in Washington, DC. The Rhode Island delegation consists of John Cunningham, Delegate; Charles Shoemaker, Alternate Delegate; and myself. Also attending were Norman Baxter, Executive Director, and Newell Warde, Assistant Executive Director.

As you have probably read, the AMA took a very strong anti-tobacco stand. Although this action attracted the most public attention, it was not controversial and passed without opposition.

The malpractice crisis was the subject of much discussion. The AMA has introduced legislation into both the Senate and the House of Representatives. Known as the "Hatch bill," this legislation provides federal incentives to states passing tort reform, including limitation of lawyers' contingency fees, a cap on awards for pain and suffering, structured settlements, and elimination of the collateral source rule. States must also create a working arrangement between the disciplinary board and the state medical society to expedite constructive peer review. Passage of this legislation could be a major step in the effort to control costs. Actuarial analyses suggest that enactment of these reforms would reduce premiums by 28 per cent. The entire Rhode Island delegation, accompanied by the AMA lobbyist, visited personally with Senators Pell and Chafee and their staffs for about 30 minutes each. In addition to urging co-sponsorship and support for the Hatch bill, several other points were addressed. We asked for additional immunity for peer review records under federal anti-trust law and for the right to obtain information about allegedly incompetent doctors from professional review organizations before the allegations reach the point of requiring sanctions.

The funding of graduate medical education (GME) was discussed extensively. Medicare funds for GME are being cut drastically. This is an undeniable reality due to the attempt to balance the budget. The proposal that funding be provided to the time of first board eligibility or five years, whichever is less, is opposed by the AMA since it is discriminatory against some specialties with long residencies and against subspecialties requiring two boards. The AMA does not oppose reduction in funding for graduates of non-LCME approved medical schools.

The Medicare fee freeze was debated at some length. The issue is not whether Medicare (or any other payer) has the right to freeze payments, but whether they have the right to limit charges. It would appear blatantly discriminatory to select only one segment of the economy for price control. The AMA stance is strong on this issue and will be reinforced by lobbying efforts in Congress. Also relative to Medicare it was suggested that the requirement for attestation about diagnoses on the chart be repealed. All members are requested to write directly to Congress about this issue.

This led directly to the question of the new law in Massachusetts which ties licensure to acceptance of Medicare approved amount as payment

in full. The AMA and the Massachusetts Medical Society have filed suit jointly in court to overturn this law. Since it links licensure of a professional to qualities and actions other than professional competence and ethical standards, a very dangerous precedent is being set. Also a state law should not be able to pre-empt a federal one.

As funds are cut in federally-sponsored medical programs, it is apparent that the mechanism of paying doctors will be changed. Options include a national fee schedule, DRGs for doctors, or a relative value scale (RVS). After much consideration, the AMA favors the RVS as the least undesirable. The government has contracted with the Harvard School of Public Health to develop this system. The AMA is in the process of subcontracting with Harvard to provide professional input.

A number of reports, both scientific (AIDS and others) and socio-economic, were presented. If you are interested, they are available at the Society's offices. AMA activities include scientific policy and information, hospital and health facility relationships, health service policy, federal and state legislation and regulation, communications, political education, international medicine, health policy research, management, and support. Detailed information is available upon request.

I am pleased with the AMA and its aggressive stance in some problems and a realistic approach in all. Your support is appreciated. By the way, Rhode Island won a trophy, which we keep for a year, for gaining the largest number of AMA members in a small state.

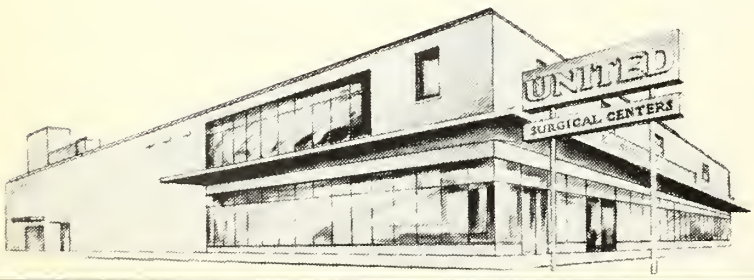
Sincerely,
Herbert Rakatansky, MD

If you have not joined the AMA, please consider it. We need to band together or we will hang separately. The AMA is our organization and provides support in many ways. It is recognized as a significant and powerful force nationally. It could be even stronger with more members.

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NECROLOGY — 1985

Robert E. Carroll, MD
Doctor Robert E. Carroll, a Providence internist and cardiologist, died October 23, 1985 at the age of 71 years.

A 1935 graduate of Providence College, Doctor Carroll received his medical degree from Tufts University in 1939. He interned at St. Joseph Hospital, Providence, and Boston City Hospital. He taught at Tufts Medical School. Chief of medicine at Navy Hospital, Newport, for a year, he was a Navy veteran of World War II. He was a member of the American Medical Association, the Rhode Island Medical Society, the Providence Medical Association, the New England Cardiovascular Society, the Massachusetts Heart Association, the Rhode Island Heart Association, and the International College of Cardiology. He also was a fellow of the American College of Cardiology.

Ulysse Forget, MD
Doctor Ulysse Forget, a Warren general practitioner, died October 5, 1985 at the age of 87 years.

A 1927 graduate of the University of Montreal Medical School, Doctor Forget completed his postgraduate training at Harvard Medical School and the New York Polyclinic Medical School and Hospital. Prior to his retirement, he served as a health officer for Warren and as an ophthalmologist for the Warren public schools. Doctor Forget was a member of the Bristol County Medical Society and the Rhode Island Medical Society.

Louis Levine, MD
Doctor Louis Levine, a Providence dermatologist before his retirement in 1980, died August 12, 1985 at the age of 79 years.

A native of Brooklyn, New York, Doctor Levine received his medical degree from the University of Glasgow in 1935. He completed his postgraduate training at Lincoln Hospital, Brooklyn, and Metropolitan Hospital, Welfare Island, New York. He served in the US Army Air Force during World War II. Doctor Levine was a member of the Rhode Island Medical Society.

Glen G. Musselman, MD
Doctor Glen G. Musselman, who joined the staff of the South County Hospital in Wakefield in 1972, died January 1, 1985 at the age of 79 years.

Doctor Musselman was a 1931 graduate of the University of Indiana School of Medicine and completed his internship at St. Vincent's Hospital, Indianapolis. He later moved to Terre Haute where he practiced general medicine for many years. Doctor Musselman was president of the medical staff at St. Anthony's Hospital, Terre Haute, in 1941 and served as its chief of anesthesiology for 25 years. He was a member of the Washington County Medical Society, the Rhode Island Medical Society, the Vigo County (Indiana) Medical Society, and the Indiana State Medical Association, and president of the Indiana Society of Anesthesiologists in 1960.

Doctor Musselman was the husband of Theresa Musselman.

Florence M. Ross, MD
Doctor Florence M. Ross, professor of health education and staff physician at Rhode Island College from 1922 to 1954, died January 3, 1985 at the age of 96 years.

A 1921 graduate of Tufts Medical School, Doctor Ross completed her internship at the New England Hospital for Women & Children and her postgraduate work at the Children's Hospital of Boston. Honored by the Tufts Alumni Association for 50 years of devoted service to the profession, she also was the recipient of the Rhode Island Association of Health, Physical Education, and Recreation Award of Honor and a 40-year certificate from the American Health Association. Doctor Ross was a member of the Rhode Island Medical Society.

Anthony J. Rotelli, MD
Doctor Anthony J. Rotelli, a Providence urologist, died July 12, 1985 at the age of 64 years.

A 1943 graduate of Brown University, Doctor Rotelli graduated from Tufts Medical School in 1946 and completed his internship at Rhode Island Hospital. He did further postgraduate training at the Lahey Clinic and Pratt Diagnostic Clin-

ic. A Navy veteran of World War II, Doctor Rotelli was a member of the Providence Medical Association, the Rhode Island Medical Society, and the Providence Surgical Society.

He was the husband of the late Veronica Rotelli.

Bencel L. Schiff, MD

Doctor Bencel L. Schiff, a Pawtucket dermatologist, died November 15, 1985 at the age of 76 years.

A 1932 graduate of Montpelier Medical School, Doctor Schiff completed his postgraduate training at St. Joseph's Hospital, Philadelphia; the Skin & Cancer Hospital, Philadelphia; and Bellevue Hospital, New York City. During World War II, he was a colonel and flight surgeon in the Army Air Force from 1940 to 1946 and served in the China-Burma-India theater. Doctor Schiff was also former chief of dermatology at the Veterans Administration Regional Medical Center for 30 years. He was a clinical professor emeritus at the Brown University Program in Medicine and an associate clinical professor at Boston University Medical School.

A fellow of the American College of Physicians and a member of the American Academy of Dermatology, he was a past president of the New England and Rhode Island Dermatological Societies, and a member of the American Medical Association, the Rhode Island Medical Society, and the Pawtucket Medical Association.

Doctor Schiff was the husband of Edith Schiff.

Theodorus E. Schuur, MD

Doctor Theodorus E. Schuur, a former Dutch resistance fighter who was decorated for his service by Queen Wilhelmina, died September 23, 1985 at the age of 68 years.

A native of Rotterdam, Holland, Doctor Schuur received his undergraduate and medical degrees from the University of Leyden. He set up a general practice in Portsmouth in 1958. From that time until 1970, he was the town and school physician in Portsmouth and also served as a medical examiner in Newport County. In 1970, he was appointed emergency room chief at Newport Hospital, retiring in 1979 due to illness. During World War II, he also served with the British forces in the Pacific theater. Doctor Schuur was a member of the Newport County Medical Society and the Rhode Island Medical Society.

Doctor Schuur was the husband of Joy Earle Schuur.

Daniel V. Trippoli, MD

Doctor Daniel V. Trippoli, a retired Providence surgeon, died on March 17, 1985 at the age of 84 years.

A Phi Beta Kappa graduate of Brown University in 1923, Doctor Trippoli received his medical degree from Harvard Medical School in 1927. He served his internship at the Massachusetts General Hospital and completed his postgraduate training at the Peter Bent Brigham Hospital, Boston, and Rhode Island Hospital. During World War II, he was a lieutenant commander in the Navy. Before his retirement in 1956, Doctor Trippoli was on the staffs of Rhode Island, Miriam, Roger Williams General, and the former Providence Lying-In Hospitals. His memberships included the American College of Surgeons, the Rhode Island Medical Society, and the Providence Medical Association.

Doctor Trippoli was the husband of Catharen B. Trippoli.

Barbara Veit, MD

Doctor Barbara Veit, a Newport dermatologist, died August 1, 1985 at the age of 75 years.

A native of Berlin, Doctor Veit received her medical degree from the University of Innsbruck, Austria, and served her internship at the Memorial Hospital, Pawtucket. She completed her postgraduate training at New York University Hospital. Doctor Veit was a member of the Newport County Medical Society, the Rhode Island Medical Society, and the American Medical Association.

Francis P. Vose, MD

Doctor Francis P. Vose, a Woonsocket internist and cardiologist, died June 5, 1985 at the age of 68 years.

Doctor Vose graduated from Yale Medical School in 1938. He completed his postgraduate training at the Rhode Island Hospital and Middlesex County Tuberculosis Santarium in Waltham, Massachusetts. He served in the US Navy from 1941 to 1946 as a lieutenant. Doctor Vose was a member of the Woonsocket District Medical Society and the Rhode Island Medical Society.

Doctor Vose was the husband of Marjorie L. Vose.

Eske Windsberg, MD

Doctor Eske Windsberg, formerly surgeon-in-chief at The Miriam Hospital for 14 years, died November 7, 1985 at the age of 86 years.

A 1921 graduate of Brown University, Doctor

Windsberg received his medical degree from Cornell University Medical School in 1925. He completed his postgraduate training at the University of Pennsylvania and in Vienna, Austria. Doctor Windsberg conducted a private practice in Providence from 1932 to 1963, the year he joined the staff of the Veterans Administration Regional Medical Center. He retired in 1978. He was a member of the Providence Medical Association, the Rhode Island Medical Society, and the American Medical Association.

Doctor Windsberg was the husband of the late Leona Windsberg.

Saul E. Wittes, MD

Doctor Saul E. Wittes, a Woonsocket internist, died on January 12, 1985 at the age of 76 years.

A 1933 graduate of the New York University Medical School, Doctor Wittes completed his postgraduate training at the Bellevue Hospital, New York. He was on the staffs of the Miriam Hospital, St. Joseph Hospital, Fogarty Memorial Hospital, and Woonsocket Hospital. He was an Army veteran of World War II. Doctor Wittes was a member of the Woonsocket District Medical Society and the Rhode Island Medical Society.

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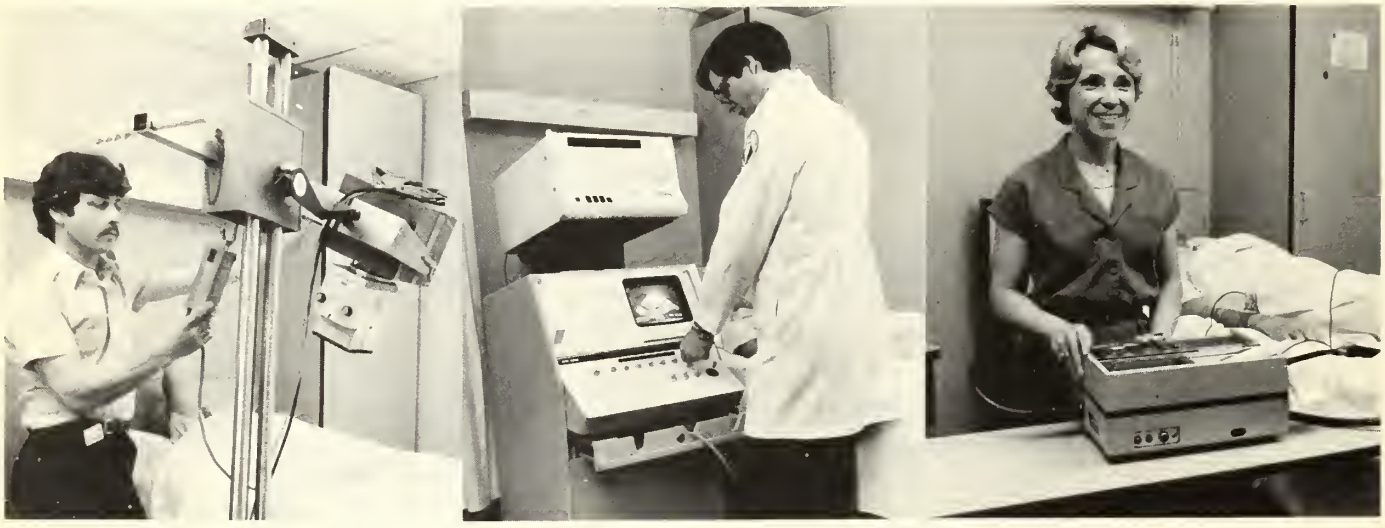
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Cape Verdean Life Expectancy

Epidemiology of Cape Verdeans, a Large Minority Population in Rhode Island, Is Inadequately Known

Richard A. Lobban, Jr, PhD
Waltraud Coli, BA
Robert J. Tidwell

The Cape Verde Islands, located off the coast of Senegal in West Africa, were first settled by European Portuguese beginning in the 1460s. The largest population to settle the islands, however, were Africans of the Mande, Fula, Balante, and other ethnic groups from the Upper Guinea coast brought to the islands as slaves.[1] During the present time the population of the islands is considered to be 71 per cent "creole" or "mestico," 28 per cent "African," and one per cent "European."[2] While the largest portion of Cape Verdeans trace their roots to Africa, specific ethnic identification has been eroded.

Subsistence on the islands was, and is, precarious with drought and famine a recurring nightmare. Between 1747 and 1970, 250,000 deaths resulted from 58 years of famine.[2] As a consequence of these conditions, emigration by Cape Verdeans to the United States and elsewhere has persisted over the centuries. Our data show a differential emigration from the various islands to the United States. The majority of the Rhode Island population came from Brava with Sao Nicolau second and Fogo third. The Southern Islands, of which Brava and Fogo are part, contributed over twice as many emigrants as did the Northern Islands.

Whalers found the Cape Verde Islands to be a ready source of cheap, but reliable, labor. Generally, during the mid 1800s to the early 1900s, it was young males from the lower classes who signed onto whaling vessels. Whaling was a dangerous occupation, but these young men found that they were respected for their hard work. For others, the danger involved in whaling inspired them to change to merchant ships or textile mills.[3]

The first permanent expression of a Cape Verdean-American population might be said to have begun in 1864 when immigration records show the first Cape Verdean female arriving in New Bedford. Immigration fluctuated greatly thereafter. While there was an average of 28 immigrants per year between 1860 and 1887, the inflow leapt forward to an average of 204.4 from 1889 to 1899, and skyrocketed to a yearly average of 837 during the 1900-1920 period. Thereafter, during the 1921-1934 period, for example, it fell to 188.6 immigrants per year. Florey and Cuadrado state that the Cape Verdean-American population reached 30,000 by 1924.[4]

Materials and Methods

In the United States, Cape Verdean-Americans are to be found everywhere, but overwhelmingly they are located in southeastern New England. The region of southern Massachusetts contains the highest concentration of Cape Verdeans in any place in the world outside the Cape Verde Island archipelago. The town of New Bedford, Massachusetts is considered to be the "Cape Verdean capital of the New World," as it traditionally has been a center for the arrival and dispersal of migrants from the islands. Fifty-eight per cent of our study population resided in New Bedford at the time of their deaths. Cape Verdeans originally came to work in the maritime industries such as whaling, packet ships, fishing, merchant marine, and the longshore industries

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as well as agricultural labor, especially in the cranberry bogs of Cape Cod. Thus, obituaries published in the two Cape Verdean monthly newspapers in the region are highly reflective of the research population. For New Bedford, the Cape Verdean community is the largest minority population.

In the 1980 census, 18,244 people officially reported at least one ancestor of Cape Verde origin. The great majority of these, 17,100 or 93.7 per cent, lived in New England. The distribution by states is as follows: 12,804 or 74.9 per cent in Massachusetts, 3,629 or 21.1 per cent in Rhode Island, and 667 or 3.9 per cent in the remaining New England states. According to Meintel, however, as many of 10-15,000 Cape Verdeans were in 1912 living in southeastern Massachusetts alone. Natural increase and further immigration has undoubtedly expanded the population far beyond the US census figure of 18,000. We consider these figures to be rather low, and the debate on the measurement and size of the Cape Verde population continues.

The population for this study is not a sample *per se;* it is the universe of cases of obituaries appearing in the *Cape Verde News* and *The Cape Verdean* during the period beween 1973 and 1983 inclusive. These are the two newspapers for a large segment of the Cape Verdean-American population which cover news from the region, nation, and overseas, especially as it relates to the Cape Verde community. We have assumed that by reason of Cape Verdean self-identity the subject population is entirely of Cape Verde origin or extraction. We are certain that some number of Cape Verdean deaths are not reported, since the submission of obituaries is voluntary and regional. We have detected only one consistent bias which might deliberately exclude anyone wishing to have an obituary published; the small number of infant deaths suggests that they are probably under-reported. Since there is no known comparable research base, however, we consider this study as pioneering. Other research is now underway analyzing early 20th century immigration records of more than 20,000 Cape Verdeans. Most official sources of vital statistics do not even register Cape Verdeans as a distinct population but, at best, may have this group considered as "black," "Portuguese," "Afro-American," or "other." For these reasons we felt it appropriate to study this "universal" research population, rather than a more limited random sample.

Our data show that males are more heavily represented in this population, but we have concluded that this is mainly due to the fact that at least 29.4 per cent of the population of Cape Verdean-Americans is made up of migrants from the islands. These migrants are self-selected, as young males represent 70.5 per cent of the migrant population. Any further disparity which might exist could be explained by the fact that the population now dying was created at a time when the bulk of Cape Verdean migration to the United States was taking place. The sex composition of the overall research population was 64.4 per cent male and 35.6 per cent female.

The research variable categories were formed by using the descriptions found in the obituaries. Some attempt was made to form a new category "class" by building from information on education and occupation, but this was not wholly satisfactory since education was rarely reported. The lack of consistent reporting was a limitation on this study. The most consistent and reliable data were found to be sex, age at death, occupation, marital status, year of birth, birthplace, origin in the Cape Verde Islands (although specific islands were not always given), religious and social affiliations, and occasionally military experience for males. Other information which might have led to the formation of a strong class or socially distinct variable was weak. This was particularly problematic with information which might have distinguished levels of education. We were tempted to conclude that those with high school or college education would have indicated this, but we did not feel it was warranted to consider that no reference to education meant that no higher education took place.

Information on the actual cause of death was a further disappointment. The predominant cause was listed as "illness," and the accompanying information on duration was typically noted as being "extended," "brief," or "unexpected." We sought to discern any relationship that these categories of duration might have with diseases such as heart disease, cancer, or other common causes of death, but we could not make any such positive association. More detailed analyses of Cape Verdean epidemiology and causes of death would have to be built from the examination of the individual death certificates of those 777 named in our research population.

Another attempt to obtain a variable indicator of social status was through the context of death (whether at home or in a hospital), or which hospital and funeral home were used. There is still some possibility that such correlations might exist, but we hesitate to state here that we have

Table 1. — Comparative Life Expectancies (mean number of years lived)

	Overall	Males	Females
Migrants from Cape Verde Islands	82.1	79.9	82.8
Rhode Island general population	75.3	71.9	78.8
United States general population, 1975	72.5	68.7	76.5
Massachusetts 1969-1971	71.8	68.1	76.5
Total research population	66.5	65.7	67.8
Rhode Island "non-whites"	—	63.4	66.8
Cape Verdean-American (US born)	60.3	57.5	63.9
Cape Verde Islands general population	—	48.3	51.7

satisfactorily established these socio-economic correlations.

Results

The population of 777 deceased Cape Verdeans may be divided into three distinct groups: Cape Verdeans born in the islands (n = 230), those of Cape Verdean descent born in the United States (n = 259), and those where information on origin was not available (n = 288). We were then able to compare these groups, in reference of life expectancy, with other groups such as native Cape Verdeans and "white" and "black" Americans. The findings generated by this comparative work show distinct differences in average life expectancy between groups within our population. The most notable differences, however, were found between immigrants and later generations.

These data also show a significant difference in life expectancy between Cape Verdeans who stayed in the islands and those who migrated. In general, life expectancy in the Cape Verde Islands is 48.3 years for males and 51.7 years for females. In contrast with these figures, the average life expectancy for Cape Verde immigrants in our population is 82.1 years. We assume this difference to be due to two principal factors. One of these is self-selection for emigration of young healthy individuals; within our research population, the majority of emigrants were under 21 years of age. The other is that the remaining population had higher mortality due to recurring conditions of drought and starvation. Even in the best of times the food supply was irregular, health care and sanitation poor, and water scarce. Perhaps the largest single factor affecting mortality figures for Cape Verde is the extremely high infant death rate, which in 1968 was 92 per 1,000. In the 1970s, it decreased to 79 per 1,000.[2]

It was found that of the emigrants from the islands, 41.4 per cent lived to be 81-90 years of age and 18.9 per cent lived to be 91 or older. In contrast, among Cape Verdeans born outside the islands only 8.9 per cent lived to be 81-90 years of age and 2.3 per cent to be 91 or older. Of males born in the islands, 78.8 per cent lived to be 71 years or older. Of males born outside the islands, only 18.8 per cent lived to be 71 or older. In fact, 65.5 per cent died between the ages of 41 and 70.

In the subsample of migrants of Cape Verde origin, the greatest number of migrants were from Brava (n = 78), Sao Nicolau n = 29), and Fogo (n = 27). While these numbers were not great, we can say that those from Brava have a comparably lower lifetime for both sexes: 75.9 for males and 81.4 for females. For Sao Nicolau the males averaged 86 years and the females 87.9 years. The results from Fogo were mixed by sex, with a low of 78.0 for males and a median for women at 84. There were only four women, however, from Fogo. Of all females from the islands 88.1 per cent lived to be 71 years or older. For the total subsample population of Cape Verdean-born, the mean lifetime for both sexes was 82.1; for males it was 79.9, and for females 82.8 years.

For the subsample of Cape Verdeans who were born in America, the mean lifetime was 60.3 years for both sexes or 57.5 for males and 63.9 for females. In contrast to longevity in the islands, only 37.7 per cent of female Cape Verdeans born in the United States lived to be 71 years or older, and 46.5 per cent died between the ages of 41 and 70. Our total research population had a mean lifetime of 63.4 years — 65.8 for males and 67.9 for females.

Discussion

When these statistics are contrasted with overall American and regional patterns of life expectancy, there are other points of notable difference (Table 1). According to the United States Public Health Service, the average lifetime for all Americans in 1975 was 72.5 for all races and both sexes,

or 68.7 for males and 76.5 for females.[6] For Massachusetts it was 71.83 for both sexes and all races, or 68.1 for males and 75.4 for females. For Rhode Island it was 75.3 for both sexes and all races, or 71.9 for males and 78.8 for females.[7] The report on vital statistics for Rhode Island notes that "non-whites" are "consistently below the national and state medians," and lists a life expectancy of only 63.4 for "non-white" males in Rhode Island and 66.8 years for "non-white" females.

Several conclusions can be drawn from this data. First, all of the subsamples conform to the general, regional, and national pattern of having females outlive males on the average. Second, the subsample of migrants from the islands is skewed in several ways. It eliminates the cohorts having high infant mortality, and it is significantly skewed toward young males, especially those in excellent health. Such factors may well explain the high level of life expectancy of this population which exceeds those in the wider American population in all respects. Nevertheless, there is notable longevity among this population, which seems to vary by island suggesting that diet, caloric intake, levels of aerobic exercise by terrain, and so forth, may be factors for further study in the archipelago. Third, when the Cape Verdeans of American birth are isolated for examination, or when they are merged with the long-living foreign-born Cape Verdeans, a life expectancy pattern emerges which falls below national and regional averages in comparison to statistics for the states of Rhode Island and Massachusetts.

Finally, we can state that the life expectancy of Cape Verdean Americans is actually lower than the levels of other "non-white" American populations, which are already lower than regional and national averages. The sample size and the various subsamples have given us confidence about these results, and they suggest that established patterns of socio-economic discrimination in America may be having a telling effect on this immigrant population which is ethnically encapsulated and racially distinguished.

Rhode Island College
Providence, Rhode Island

Summary

Cape Verdean Americans are not a well-known ethnic group outside of southeastern New England. Even their basic population size, demography, and immigration patterns are crudely defined.[4] As a contribution toward the fuller study of this group, an effort has been made to look at one aspect of this unique ethnic group by determining their overall life expectancy as derived from an analysis of 777 obituary announcements. This study also reveals aspects of the history and scale of their migration to the United States.

Acknowledgments

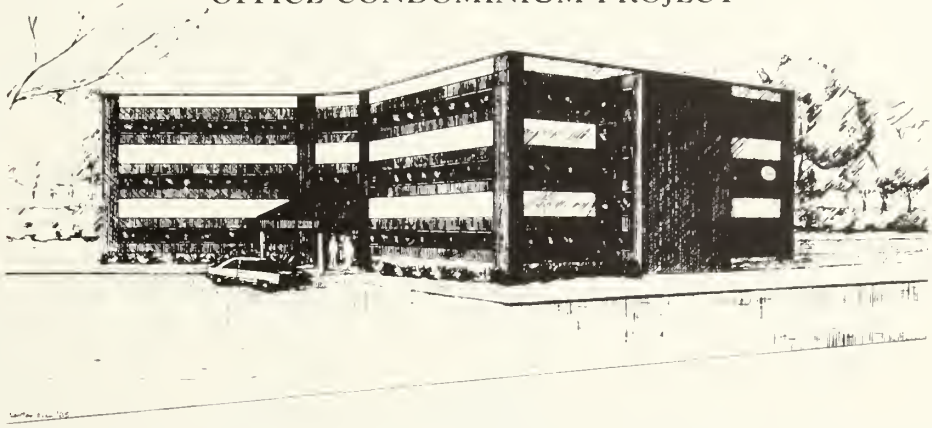
Appreciation is gratefully expressed to the Office of the Dean, Faculty of Arts and Sciences, Rhode Island College and the College Faculty Research Committee. Some aspects of the project were incorporated as illustrative examples to students in a course on anthropological methods. These students spent many hours coding, entering, and processing the data at the RIC Computer Center. These included Waltraud Coli and Robert J. Tidwell, who were research assistants, and Katherine Jackson, Cynthia Connors, Cheryl Guglielmo, and Celeste Steffanci. Thanks also to Paul Cyr of the Genealogical Section of the New Bedford Public Library, and to Marilyn Halter for providing preliminary data from her doctoral research.

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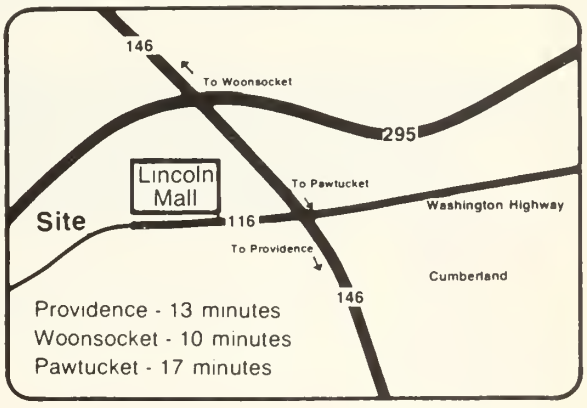
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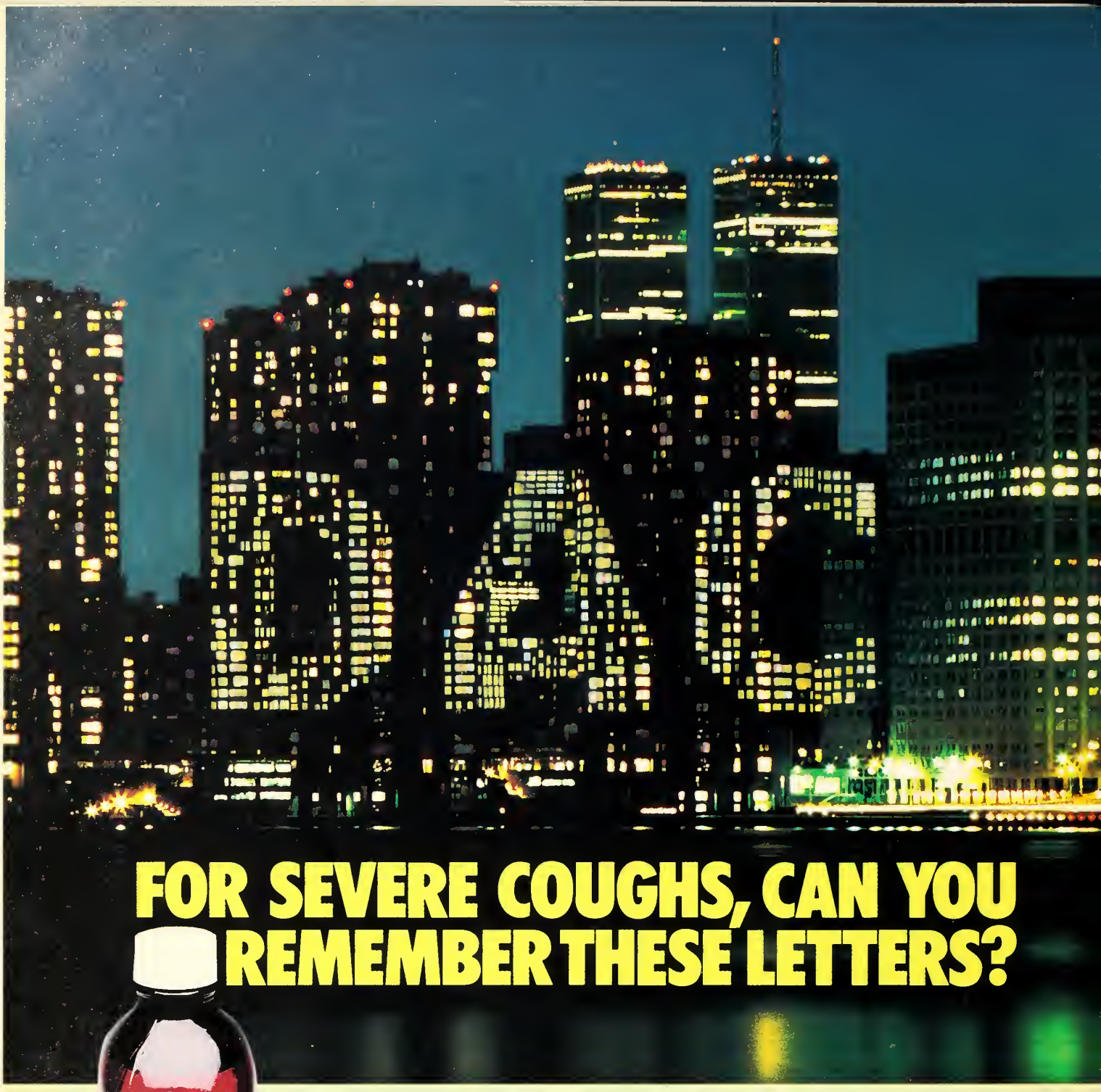


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The Indochinese Action Group

Hospital Organizes to Provide Better Health Care to Refugees with Complex Needs

Eileen Rosenberg-Black, MSW
Jeanne Gibree, BSN
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The small state of Rhode Island has in residence almost 8,000 refugees from Southeast Asia. This is more than one per cent of the Southeast Asian emigres who have sought refuge in the United States. In a large metropolitan hospital, such as Rhode Island Hospital, it is extremely difficult to coordinate comprehensive health-care services for a small group of people with such complex needs. Initially, individuals from different areas of the hospital expressed concern, but energies were unfocused and uncoordinated. At a time when public and government awareness of the refugees' situation was coming to the forefront, the Community Liaison Committee of Rhode Island Hospital, which is a subcommittee of the Board of Trustees, expressed concern with both health care and community relations and education for Southeast Asian refugees. Members of this committee were aware of the number of Southeast Asian refugees and their impact on the health-care system. This sensitivity stimulated the formation of an Indochinese Action Group whose goal was to explore further means of providing better services for the new Americans.

Because the refugees have an impact on all aspects of hospital operations, the Indochinese Action Group is a multidisciplinary committee. Members represent such varied departments as unit services, personnel, social work, community medicine, ambulatory care, pharmacy, and others. A network for support and communication was quickly developed among group members. Issues ranged from educational programs sensitizing staff to cultural differences, to interpreter problems, and to community relations. The committee was open to new members and grew rapidly.

Interpreters

Members of the Indochinese Action Group recognized that interpreters were needed to communicate with Southeast Asian patients, and the recruitment and placement of Southeast Asian employees became a focused goal. Southeast Asian employees, while functioning as part of the hospital team providing all patients with quality care, would also assist as interpreters.

The refugees heavily frequent the hospital ambulatory clinics and emergency department where the need for interpreters is greatest. The hospital personnel office formed a close working relationship with the statewide Office of Refugee Resettlement and with the Opportunities Industrialization Center of Rhode Island, Inc to seek out qualified applicants who could be placed in various hospital departments. The hospital administration, recognizing the need to employ the new Southeast Asian neighbors, exempted potential jobs in key patient areas from a hiring freeze. Job classifications which Southeast Asian employees hold include unit receptionist, messenger, food service worker, central transport aide, unit service aide, laboratory aide, nursing assistant, patient services secretary, and pharmacy technician. Southeast Asian employees work on both day and evening shifts.

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The personnel staff has attended several programs to learn more about the culture of the various Southeast Asian groups. With the cooperation of the Rhode Island Office of Refugee Resettlement, an in-service session was held to explore cultural differences related to job seeking and work habits. Methods of assisting hospital supervisors and Southeast Asian applicants during the interview process were also examined.

Since beginning this program, there have been some turnover of staff and a few problems. Initially Southeast Asian employees functioning as unit receptionists had problems with communication because of the complexity of medical language. This created a problem when taking laboratory reports over the telephone and with requests made by the nursing staff regarding supplies and equipment. The training program was changed to accommodate the Southeast Asian employees recognizing that it would take longer to train them because of this language barrier. Southeast Asian employees were under stress during their training period and the unit service department employees shared in this stress because of the staffing shortage. This situation was an added barrier to learning new responsibilities. Many hospital employees provided as much support as possible to the new Americans, and presently Southeast Asians are functioning as unit receptionists and are performing all of the required responsibilities. Most supervisors indicate that the Southeast Asians are cooperative, pleasant, courteous, and extremely reliable.

Another difficult problem, which stems from the fact that the Southeast Asian employees are used as interpreters, is the employee's concern about being taken from a job for long periods of time to interpret. They recognize that this burdens their co-workers with extra work. Also there is the concern about being unable to take on a position of responsibility because of the necessity of leaving the job to interpret. This has proved to be a difficult dilemma. Because of the variety of Indochinese languages and the fact that it is very difficult to cover all of the languages on all shifts with full-time interpreters, it is necessary for the administration and supervisors to support Southeast Asian workers who are taken away from their jobs to interpret.

To provide interpreter assistance to Southeast Asian patients, it is necessary to identify such individuals as they enter the hospital, especially since there are so many different languages. The language or dialect of each non-English-speaking patient is captured on an admitting history, which is distributed throughout the hospital. The language spoken also appears on the face sheet which is a permanent part of the medical record. Moreover, when a patient is a member of a Southeast Asian community, a representative of the admitting department contacts the Southeast Asian Health Coordination Unit of the Visiting Nurses Association. This liaison facilitates better planning and coordination of the patient's health care.

Liaison Nurses

In the outpatient department there is a nurse designated to act as a liaison between the ambulatory patient center clinics and the Southeast Asian Health Coordinating Unit. This allows easier access to the system by providing one person familiar with the hospital to coordinate appointments and interpreters. The nurse liaison receives a computer printout three days before the patient is coming to the clinic so that she can make the necessary arrangements. If there are problems or questions regarding treatment or follow-up care, and these are unclear to the patient, the liaison person is able to obtain additional information. In addition to telephone communication, a three-copy interagency form is used in the clinic area. Two copies are sent to the Southeast Asian Health Coordination Unit of the VNA, and one copy is kept for reference by the liaison nurse. This has been very helpful in reinforcing teaching by giving the same information to the health coordinators that was given to the patient. By designating one person in the area as a liaison staff, much confusion and frustration have been avoided.

Dietary Habits

Because more and more Southeast Asians are using Rhode Island Hospital, it has become necessary to heighten awareness of dietary habits. For example, the Hmong people from the mountainous area of Laos enjoy plain beef, chicken, or pork with soy sauce on the side, rice three times daily, hot soup, vegetables, hot tea, and spice. For breakfast they eat some of these foods just as they do for the evening meal. The older people do not eat sweets. Since the Hmong have no written language, a special menu could not be written for them. Cambodians tend to eat more seafood than do the other groups. Many Southeast Asians are lactose-intolerant and cannot digest milk or milk products. A predominant belief is that of the "ying" and "yang" for cold and

hot foods. Disease states are treated with opposing foods. For example, pregnancy, a "ying" or cold condition, is treated with "yang" or hot foods. No cold liquids are consumed.

As the result of a meeting with Southeast Asian representatives, preplanned menus observing the food habits are available whenever needed so that Southeast Asian food customs can be observed by hospital patients if they so desire. Specialized food items are also kept on hand to make specialized recipes if needed. Interestingly enough as Southeast Asians become Americanized, there is an occasional complaint, "Why am I getting so much chicken? Can't I please have a hamburger?"

Hospital Tours

Fear and anxiety even for English-speaking patients often accompany visits to the hospital. To help alleviate this problem and to familiarize the Southeast Asian community with the Rhode Island Hospital and Western medicine and practices, tours of the emergency department were arranged. These tours begin with a slide tape presentation and narrative by Indochinese Action Group members and include a guided tour through various areas of the emergency department as well as the x-ray department, laboratories, and adult medical and surgical units. The response to these tours has been very positive and the result has been increased utilization of Rhode Island Hospital facilities.

The Indochinese Action Group has hosted many guest speakers at meetings. This has been helpful in gathering information to provide better services to the Southeast Asian community. One of the first speakers was a representative from the Rhode Island Office of Refugee Resettlement, who gave an overview on the function and responsibilities of a central health unit. The coordinators and nursing supervisors of the Southeast Asian Health Coordination Unit addressed the group, explaining their roles and responsibilities in the health care system. The director of the Rape Crisis Center spoke with the group about some of her experiences with members of the Southeast Asian community and some implications for follow-up care. Staff from a neighboring hospital, which also serves the Southeast Asian community, attended a meeting and shared experiences. This resulted in a follow-up meeting at their hospital and an exchange of teaching materials. The Group also invited a Christian missionary couple who spoke of their extensive experiences in Cambodia. The couple presently is working at a local Cambodian church and provided the group with considerable insight into the problems faced by this community.

As the Indochinese Action Group grew in size and in projects, members realized that many of the problems faced by the Southeast Asian community were problems shared by all of the hospital's non-English speaking patients. The Group then invited representatives from Hispanic communities to attend a meeting and share some of their concerns about health care. As a result of this meeting the Group decided to address the needs of all ethnic groups, leading to the formation of the Ethnic Issues Action Group.

Goals

To establish a sense of continuity and structure, the Ethnic Issues Action Group conducted a poll of all members to determine goals for the following year. The group consensus emerged into the following structured goals:

(1) To develop an increased awareness of cultural and ethnic differences, become more familiar with specific ethnic groups and their utilization of health care services, and increase access to health care. In order to implement this goal, the following plan was proposed: to develop a comprehensive system to assess and coordinate the needs of all non-English speaking patients and to educate personnel on ethnic issues.

(2) To develop materials which will enhance the patient's ability to utilize hospital services and to improve communication among hospital personnel about the needs of patients and their families. The plan for implementation includes: to develop an informational and directional system to service areas in the hospital including both changes in signs and the use of volunteers; to develop discharge planning and teaching materials for the various ethnic groups; and to investigate and obtain written material from local associations, educational institutions, and other sources to foster knowledge of what is available to non-English-speaking patients. Committee members will seek funding for the development of materials.

(3) To resolve problem issues as they arise. This goal will be accomplished through the following plan: to act as a recognized liaison to administration; and to increase committee membership to be representative of most hospital departments by inviting members from administration, medical records, additional nursing representation, patient representatives, and the telephone office.

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Fanconi Syndrome and Osteomalacia without Hyperparathyroidism

Fanconi Syndrome Associated with Defective Renal Handling of Phosphate and Acidemia, Calciuria, and Altered Vitamin D Metabolism

S. Khoury, MD
Joseph R. Tucci, MD

Hypophosphatemic osteomalacia with pseudofractures is the characteristic skeletal abnormality complicating the proximal (type II) renal tubular acidosis (RTA) of the adult Fanconi syndrome.[1, 2] Secondary hyperparathyroidism is usually present and is thought to contribute to the renal tubular defects and to the skeletal disease.[3, 4] In hereditary fructose intolerance, the fructose-induced Fanconi syndrome is only manifest when exogenous parathyroid hormone (PTH) is administered together with the fructose load to a hypoparathyroid patient.[5] Other factors contributing to the metabolic bone disease found in Fanconi syndrome include acidemia, hypophosphatemia, hypercalciuria, changes in vitamin D metabolism, and the interrelationship between these factors and PTH. Although it is now well-established that both hypophosphatemia and PTH have a stimulatory effect on the production of 1,25-dihydroxy vitamin D (1,25-$(OH)_2D$),[6, 7] controversy still exists concerning the effect of chronic acidemia on the metabolism of this hormone.[8-10] Serum concentrations of 25-hydroxy vitamin D (25-OHD) and 1,25-$(OH)_2D$ have not been reported in this disorder, except for one case of acetazolamide-induced RTA where levels were low and normal, respectively.[11] This was, however, in the setting of concomitant use of anticonvulsant drugs.

Recently we studied a patient with the adult Fanconi syndrome and osteomalacia. The absence of a secondary hyperparathyroid state presented us with an unusual opportunity to study some of the controversial and interrelating factors involved in the disturbed mineral and skeletal homeostasis of this entity.

Case Report

A 55-year-old white woman presented with a ten-year history of osteopenia and pathological fractures and increasing muscular weakness. A calcium-containing kidney stone was surgically removed at age 26 years and another was passed spontaneously at 40 years of age. She had repeated neck surgery for a thyroglossal cyst and subsequently was treated with desiccated thyroid following development of hypothyroidism. She had normal body proportions and no deformities. She had a mild hyperchloremic acidosis with serum bicarbonate levels of 17 to 20 mEq/L and serum chloride of 115 to 118 mEq/L. Serum sodium and potassium levels were normal. Urinary pH was consistently greater than 7.0. She had a generalized aminoaciduria, low threshold glycosuria, and uricosuria. She excreted more than 15 per cent of an infused bicarbonate load when bicarbonate concentration was raised to and above the normal level. Serum creatinine values averaged 1.5 mg per cent, and endogenous creatinine clearances averaged 47 ml/minute per 1.73 M^2. There was no paraproteinuria or history of exposure to heavy metals. She was on no medication except for desiccated thyroid and

Presented in part at the Frances and Anthony D'Anna International Memorial Symposium, Dearborn, Michigan, May 1983

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she was euthyroid. Serum alkaline phosphatase was elevated and of bony origin. Urinary hydroxyproline was increased. A skeletal survey revealed generalized osteopenia and pseudofractures, and histological findings on bone biopsy were consistent with osteomalacia.

After metabolic studies were completed, she was sequentially treated with $NaHCO_3$, Neutraphos®, and vitamin D_2 (ergocalciferol). With up to 8 g of $NaHCO_3$, serum electrolytes became normal. With phosphorus supplementation of 1.5 to 2.0 g per day, serum phosphate levels rose to normal, and with vitamin D_2 supplementation in doses of 50,000 units three times weekly, the patient felt better than she had in many years. Muscle strength returned to normal, eliminating the need for a cane.

Materials and Methods

Metabolic studies were performed after equilibration on a diet containing 150 mg calcium and 500 mg phosphorus per day. Study A was designed to collect baseline data and to assess the absorption of and the response to an oral calcium challenge. The first and second days were control days and urine was collected for 24-hour periods. On the third day, the patient was water loaded and hydration continued to assure adequate urine flow. Timed urine specimens were collected from 9:00 am until 8:00 am the following morning. One gram of elemental calcium as calcium gluconate (44 ml of Neocalglucon®) was given orally at 10:00 am. Blood specimens were drawn with the patient supine on the first and second days at 8:00 am and on the third day at 8:00 am, 12:00 pm, and 2:00 pm.

Study B was designed to test parathyroid reserve in response to hypocalcemia. Serum and urine samples were collected before and after oral supplementation with two grams of elemental phosphorus daily for two days and after infusion of two liters of 0.9 per cent sodium chloride over a four-hour period the next day. Urine specimens were immediately analyzed for their creatinine, calcium, and phosphate contents, and aliquots were frozen for subsequent measurement of cyclic AMP. All blood specimens were analyzed for their creatinine, total calcium, phosphate, ionized calcium, PTH, and cyclic AMP levels and control blood specimens for 25-OHD and 1,25-$(OH)_2$D levels. Urinary cyclic AMP was measured by a competitive binding assay and plasma cyclic AMP by radioimmunoassay. Urinary and nephrogenous cyclic AMP were expressed per dL GF. TMP/dL GF was estimated from measurements of tubular reabsorption of phosphate (TRP) and the nomogram of Walton and Bijvoet.[12] Serum carboxyterminal PTH, 25-OHD, and 1,25-$(OH)_2$D assays were performed by the Nichols Institute, San Pedro, California.

Results

Study A (Table 1): In the basal state, serum calcium and ionized calcium levels were low normal to low, serum phosphate was subnormal, and serum PTH was normal. Urinary calcium excretion was increased in the face of a marginal serum calcium. TMP/dL GF was low in keeping with urinary phosphate wastage. Serum and urinary magnesium were well within normal limits. Urinary and nephrogenous cyclic AMP excretion were normal. Serum 25-OHD levels were low at 8 and 7 ng/mL (normal 10-55), and 1,25-$(OH)_2$D levels were normal at 29, 28, and 26 pg/mL (normal 20-76). The oral calcium load was followed by calcemic and calciuric responses, a more than 50 per cent fall in urinary cyclic AMP, almost complete disappearance of nephrogenous cyclic AMP, but no change in TMP/dL GF.

Study B (Table 2): Phosphorus supplementation effected a modest decrease in serum calcium, an increase in serum and urinary phosphate, and a dramatic fall in urinary calcium excretion. There was no change in urinary or nephrogenous cyclic AMP. With the infusion of the saline solution, although there was a further fall in serum calcium and a rise in urinary calcium, there was no change in serum PTH, or urinary or nephrogenous cyclic AMP.

Discussion

This patient exhibited many of the classical features of acquired type II RTA. The relevance of the patient's earlier history of urolithiasis is unclear since stone formation is rarely encountered in this syndrome.[1] The absence of hyperparathyroidism in the face of hypocalcemia presented us with an unusual opportunity to study some of the controversial and interrelating factors involved in the disturbed mineral and skeletal homeostatis of this entity. Morris et al suggested a pathogenetic role for excess endogenous PTH in their case of hereditary fructose intolerance.[5] Some patients with hereditary hypophosphatemic rickets may have an exaggerated phosphaturic response to physiological concentration of PTH in eucalcemic and hypercalcemic states, possibly as part of a genetic syndrome.[13] In this patient the finding of low

Table 1. — Serum and urine data before and after an oral calcium load

	Urine					Blood			
	Ca (mg)	Ca/Cr	TMP (mg/dLGF)	UcAMP (nmol/dLGF)	NcAMP		Ca (mg/dL)	P (mg/dL)	PTH uIEq/mL
Normal Values	50-225	.03-.17	2.5-4.2	2.2-4.8	0.8-3.5		8.5-10.5	2.5-4.5	40-100
Time						Time			
0800-0800	152	.16	1.51	1.88	0.72	0800	8.2	2.4	65
0800-0800	140	.17	1.50	4.20	2.86	0800	8.5	2.5	56
0900-1000	6	.16	1.68	4.35	3.01	0800	8.4	2.6	65
1000*1200	21	.22	1.49	1.36	0.01	1200	8.6	2.4	—
1200-1400	19	.22	1.52	1.45	0.08	1400	8.3	2.2	57
1400-0800	165	.21	1.32	—	—				

* 1 Gm elemental calcium p.o.

Table 2. — Serum and urine data before and after oral phosphorus loading and after intravenous saline administration

		Urine						Blood			
Days	Time	Ca	P	Ca/Cr	UcAMP	NcAMP	Time	Ca	IoCa*	P	PTH
Control	0800-0800	94	441	.12	—	—	0800	9.0	—	2.1	—
2g P/d ⟶	0800-0800	80	681	.12	4.28	2.68		—	—	—	—
2g P/d ⟶	0800-0800	9	1047	.01	4.90	3.30	0800	8.1	—	3.0	—
	0800-1000	1	98	.01	—	—		—	—	—	—
2L 0.9% NaCl ⟶	1000-1400	40	155	.35	4.37	2.77	1000	8.5	4.2	3.0	66
	1400-0800	110	575	.23	—	—	1400	7.7	3.8	2.9	79

* Normal range, 4.5-5.0 mg/dl.

normal to subnormal serum calcium levels and unchanging serum PTH and urinary and nephrogenous cyclic AMP within the normal range, despite induced further falls in serum calcium following phosphate supplementation or intravenous saline administration, raised the possibility of a mild or partial surgical hypoparathyroid state. Therefore, although secondary hyperparathyroidism has been implicated in the pathogenesis of the renotubular dysfunction and metabolic bone disease in Fanconi syndrome,[1] in this patient a secondary hyperparathyroid state can be excluded as playing such a role. This is supported by recent similar observations in a patient with Wilson's disease and related hypoparathyroidism and Fanconi syndrome.[14]

Other factors implicated in the development of osteomalacia include hypophosphatemia, acidemia, calciuria, and alterations in the vitamin D metabolism.[1] Acidemia-induced hypercalciuria is in part related to a direct renotubular effect.[15] Acidemia has also been implicated in an enhanced remodeling effect of PTH on bone and enhanced PTH secretion.[16] The latter effect has been challenged, since no change in serum PTH was noted during chronic ammonium chloride-induced metabolic acidosis.[9] An impaired conversion of 25-OHD and 1,25-$(OH)_2$D was reported in Fanconi syndrome induced by maleic acid and studies in ammonium chloride-treated rachitic chicks suggested a decrease in production, increase in clearance of 1,25-$(OH)_2$D, or

both.[17] For unexplained reasons, this patient did have low serum 25-OHD levels in keeping with a vitamin D deficient state, and normal serum 1,25-$(OH)_2D$. There was no evidence of malabsorption, nutritional aberrations, hepatic dysfunction, or ingestion of drugs active in stimulating hepatic microsomal enzymes. Similar 25-OHD levels have been reported in a patient with acetazolamide-induced RTA who was receiving anticonvulsant drugs.[11] In this patient no specific tests were done to exclude a selective defect in the absorption of vitamin D and 25-OHD.

Osteomalacia in the face of normal circulating 1,25-$(OH)_2D$ is not surprising, as similar findings have been reported in patients receiving anticonvulsant drugs, in nutritional osteomalacia, and in hereditary hypophosphatemic osteopenia.[18-20] Such observations suggest that serum phosphate and 1,25-$(OH)_2D$ may have independent effects on bone mineralization. Also, other metabolites of vitamin D such as 24,25-$(OH)_2D$ may play a critical role in bone mineralization.[21]

In this patient, despite proximal tubular defects and in keeping with a previous report, phosphorus administration almost eliminated the urinary excretion of calcium.[22] Such an effect cannot be attributed to an increase in parathyroid hormone secretion. It may have involved an action at sites other than the proximal tubule and distinct from the distal tubular site of action of PTH.

Summary

A 55-year-old women presented with a ten-year history of bone pain, rib fractures, and increasing muscle weakness and was found to have a hyperchloremic acidosis, aminoaciduria, glycosuria, and a urine pH greater than 7.0. X-ray studies revealed osteopenia and pseudofractures, and osteomalacia was found on bone biopsy. In the face of normal indices of parathyroid function she had hypocalcemia, relative hypercalciuria, hyperphosphaturia, and hypophosphatemia. Serum 25-OHD levels were low and in the face of acidemia the osteomalacia was associated with normal serum 1,25-$(OH)_2D$. Gastrointestinal absorption of calcium and phosphate were normal, and oral phosphorus loading almost eliminated urine calcium excretion. These studies exclude malabsorption of calcium and phosphate and hyperparathyroidism as pathophysiologic factors in Fanconi syndrome and suggest that the clinical and chemical manifestations of this syndrome are attributable to a primary defect in renal handling of phosphate, associated acidemia, calciuria, and changes in vitamin D metabolism.

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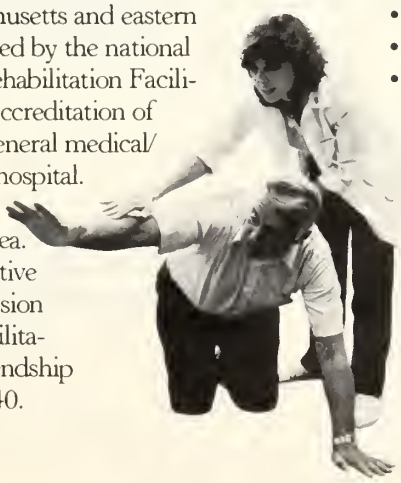


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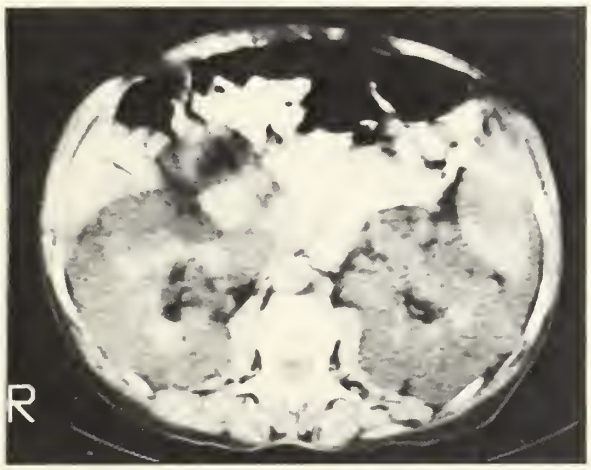


Fig 1. — CT demonstrates enlargement of both kidneys with multiple cysts



Fig 2. — Tomography shows bilaterally enlarged kidneys with distortion of the calyces.

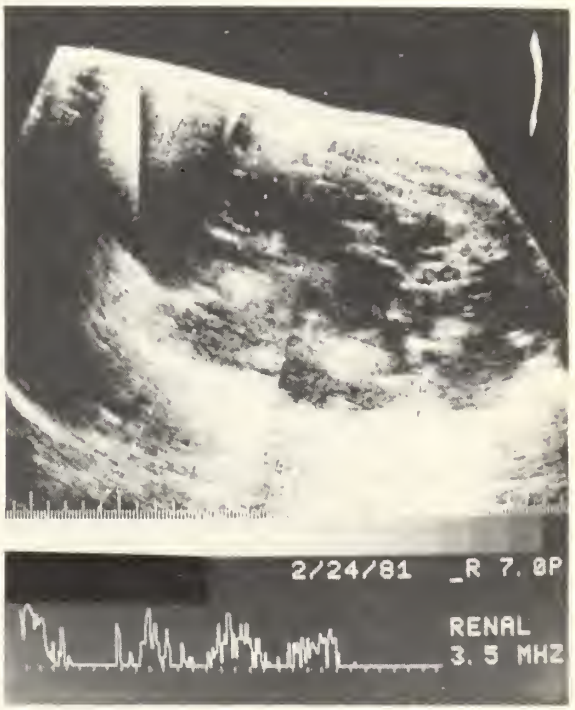


Fig 3. — Longitudinal ultrasound (from another patient with less severe involvement) shows renal enlargement with multiple cysts. The reniform shape is maintained.

History

This elderly woman was admitted because of left lower quadrant pain. The CT scan was performed in the course of her workup.

For discussion turn to next page.

Radiographic Findings
An axial computed tomographic (CT) scan through the region of the kidneys demonstrates marked enlargement of the kidneys with multiple diffuse cysts.

Diagnosis
Adult polycystic kidney disease

Discussion
The CT scan (Fig 1), intravenous pyelogram (IVP) (Fig 2), and ultrasound demonstrate the typical findings of adult polycystic kidneys (APK).

Typically the kidneys in APK are bilaterally enlarged, but maintain the reniform shape. Multiple cysts of varying sizes are seen diffusely throughout the kidneys with varying degrees of caliceal distortion and occasionally blunting of calyces. Large cysts may compress the renal pelvis or ureter and cause renal obstruction. The disease is bilateral, although there may be marked discrepancies in involvement. It is not unusual to have such minimal involvement in one kidney that there is practically no enlargement and the cysts are barely discernable by any modality. When the cysts are very numerous and clustered, there may be the typical "Swiss cheese" appearance demonstrated on ultrasound and computerized tomography. Ultrasound together with CT can also depict complications of polycystic kidneys such as bleeding into a cyst, calcification, and carcinoma.

Adult polycystic disease occurs with an incidence of one per 1,000 population, although autopsy results demonstrate a much higher occurrence due to the fact that many cases remain clinically asymptomatic.[1, 2] The etiology is unknown, but the theory most widely recognized is a failure of the uriniferous tubules of nephrogenic blastema to connect with the collecting tubules of the ureteric bud.[3] Another theory is that a toxic metabolite, diphenylamine, causes cystic changes in the collecting tubules.

Typically, there is enlargement of the kidneys with multiple cysts dispersed through the cortex and medulla, but the renal shape is maintained. Cysts may contain serous fluid, blood, or urine. The distribution may not be uniform, and there are often areas of normal tissue interspersed with the cysts.

Adult polycystic disease is inherited as an autosomal dominant and has a high penetrance. Asymptomatic patients, diagnosed by chance, live a normal life span, often into their 80s. Clinical manifestations usually become apparent in the fourth or fifth decade and may present as abdominal, flank, or back pain. The enlarging cysts may present as an abdominal mass or may cause obstruction resulting in pain, calculus formation, and pyelonephritis. Cyst rupture may result in hematuria. Hypertension is often present. If significant renal parenchyma is replaced, nephrotic syndrome and uremia will follow.

One-fourth to one-third of patients with APK will have liver cysts. Approximately nine per cent have pancreatic cysts. There also may be cysts in the lungs, spleen, ovaries, testes, thyroid, uterus, and bladder.[3] Since 1901 there have been 50 cases of berry aneurysms found in patients with APK. In one series of 173 cases there was an 11 per cent incidence of cerebral aneurysms. It is difficult to determine in these cases whether the aneurysms were secondary to the hypertension associated with polycystic disease. APK also has been reported in patients with neurofibromatosis. There have been 17 cases of carcinoma found in patients with APK. Most of these were not suspected before surgery.

With moderate or marked bilateral involvement, the appearance of APK on intravenous pyelography, CT, and ultrasound virtually is enough to exclude other abnormalities. In cases of minimal involvement of one kidney, however, other entities have to be considered. The multiple harmartomas of tuberous sclerosis may be confusing on standard intravenous pyelography. However, CT and ultrasound demonstrate solid masses and rule out this possibility. Perhaps the hardest entity to distinguish from APK is multiple bilateral cysts of the kidneys. Indeed, as such cysts are multiple, small, and involve both kidneys, it may be impossible to differentiate from APK.

Before the days of renal transplantation, treatment was palliative with poor results and high morbidity. Currently, transplantation is performed in severe cases. Because cadaver transplants have to be used as there is a high probability of polycystic disease in relatives, rejection remains a problem. Some patients survive on dialysis.

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HAVE YOU HEARD? . . .

A survey of 1,844 lower income women shows a significantly earlier onset of puberty for adolescents (12 to 16 years) experiencing their first pregnancy compared with adults (17 to 31 years), according to a report in the October 1985 *American Journal of Diseases of Children.* In addition, the adolescent mothers-to-be were taller and heavier (prepregnancy) than National Center for Health Statistics standards and had a significantly greater weight-for-height ratio, report Doctor Charles Hoff and his colleagues from the University of South Alabama Medical Center in Mobile. "These comparative findings have relevance both to the maturational status of the Mobile patients and to the impact of government assistance on the health and well-being of these patients," they say.

• • •

"Papulovesicular light eruption" is suggested by researchers from Kauai as a name to describe a distinct condition that commonly affects young to middle-aged white women visiting Hawaii. Reporting in the October 1985 *Archives of Dermatology,* Doctor David J. Elpern of the Kauai Medical Group and his colleagues reported on their analysis of 150 cases of papulovesicular eruptions (small solid or fluid elevations of the skin) affecting female visitors to the Pacific islands. "The majority (83 per cent) of patients resided in the more northerly mainland states and Canada," they point out, adding that most eruptions followed exposure to sunlight and are confined to exposed areas of the body.

• • •

Further evaluation of the use of heparin following transient ischemic attacks (TIAs) to prevent cerebral infarction is indicated, according to a report in the October 1985 issue of the *Archives of Neurology.* Heparin, which prevents clotting of blood, has been used following TIAs since the 1940s, but in a study of 74 patients Doctors Steven F. Putman and Harold P. Adams, Jr. of the University of Iowa Hospitals in Iowa City found that 12 patients had recurrent TIAs and five had cerebral infarction during treatment. In addition, nine patients had bleeding complications. "Further evaluation of heparin therapy is appropriate," they claim, pointing out that the only other therapeutic option now available

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would be use of antiplatelet-aggregating agents (aspirin and dipyridimole), whose value also is not known.

• • •

Sixteen self-study courses in diagnostic imaging are now available from General Electric Medical Systems for use by teaching hospitals and medical schools. The training courses have been tested in hospitals and in schools with medical curricula and have been approved for continuing education credit by the American Society of Radiologic Technologists and the Society of Nuclear Medicine. A self-guided workbook and one or more videotapes accompany all study programs. One course also features slide support. Courses of study include: basic anatomy and physiology, x-ray tubes and generators, introduction to radiographic equipment, image intensification and recording devices, introductions to vascular and digital imaging, MR imaging, CT, ultrasound, nuclear medicine imaging, and radiation treatment planning.

• • •

Long associated with occupational or environmental exposure, asbestos now has been found in infants less than ten months of age, according to a report in the March 1985 issue of the *Archives of Pathology and Laboratory Medicine*. Doctor Abida K. Haque and his colleagues from the University of Texas Medical Branch in Galveston conducted systematic examinations of 17 infants and found asbestos bodies in the lung tissue of six. Exposure may have been from asbestos sprayed on ceilings, asbestos from incubator gaskets, or from other sources in home or hospital. Concentrations were comparable with those found in some adult lung cancer patients, the researchers say. They plan further studies to determine the presence and extent of asbestos in infant lungs.

• • •

The Warner-Lambert Company recently announced that it will market the screening assay developed by Electro-Nucleonics, Inc. to detect antibodies linked to HTLV-III, a virus which is believed to cause the acquired immune deficiency syndrome (AIDS). The assay, which is intended for use by medical and health professionals, has been approved by the Food and Drug Administration (FDA). The company will market the assay under a sub-licensing agreement with Electro-Nucleonics, one of five companies licensed by the US Department of Health and Human Ser-

vices to develop an assay for HTLV-III. The Electro-Nucleonics test has been shown to detect accurately the presence of HTLV-III antibodies in 99.6 per cent of AIDS-diagnosed patients, based upon a recently completed study.

• • •

Devon Management Resources, Inc., a Yonkers, New York management consulting firm, recently announced that its computerized patient recall service for medical offices resulted in a 40 per cent average increase in patient checkup visits. George Berman, President of Devon and designer of the system, attributed the success of the test program to several factors. "To begin with, there is simply no doubt that it pays to remind patients to show up for an annual or semi-annual checkup. The trouble with an in-house patient recall system is that is places too great a burden on the doctor's office. Amidst all the work of patient service, billing, accounting, and preparation of insurance and government forms, recalling patients gets little, if any, attention." The Devon program emphasizes the importance of sending a second reminder notice. One-third of the patients responding to recall cards were found to make an appointment only after receiving a second card.

• • •

A normal electrocardiogram plus a combination of three factors offer the best clues as to whether acute chest pain will lead to myocardial infarction, according to a study from Harvard Medical School. Writing in the January 1985 issue of the *Archives of Internal Medicine,* Doctor Thomas H. Lee and his colleagues report on a study of 596 patients who came to an emergency room complaining of chest pain. A normal electrocardiogram plus stabbing pain, no history of angina, and pain reproducible by tapping the chest wall defined those patients at least risk. Some studies show that as many as 70 per cent of patients admitted to coronary care units do not have heart attacks, the researchers point out. Unfortunately, the well-defined low-risk group in their study accounted for only eight per cent of the total patients. "Improved diagnostic accuracy among low-risk patients requires the interpretation of several pieces of data from the history and physical examination, and usually requires an electrocardiogram as well," the researchers conclude.

• • •

There is a natural boundary in symptoms that distinguish schizophrenic patients from other



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psychiatric patients as well as from normal controls, according to a study in the January 1985 issue of the *Archives of General Psychiatry*.

Doctor C. Robert Cloninger and his colleagues from the Washington University School of Medicine in St. Louis studied approximately 2,000 subjects for 12 years. More than 68 per cent of schizophrenic patients had two or more of four clearly defined syndromes: delusions of persecution; delusions of control; mood-incongruent delusions; and auditory hallucinations. Less than two per cent of nonschizophrenic patients had two or more of the syndromes. "Scale scores were valuable for quantifying the certainty of diagnosis and predicting outcome," the researchers note.

• • •

Westernization of the Asian eyelid has become a topic of increasing importance among surgeons, according to a report by Doctor Ronald S. Matsunaga, University of Southern California in Los Angeles, in the March 1985 issue of *Archives of Otolaryngology*. He attributes the heightened demand for the procedure to the recent influx of Asian immigrants, and says he has performed more than 2,000 procedures aimed at giving oriental eyes an occidental look. Most surgeons settle for creating an eyelid fold, Matsunaga says. His technique includes the removal of the epicanthal web (the vertical folds of skin on either side of the nose) to complete a westernized appearance. "This is elected by almost 50 per cent of our patients," he reports.

• • •

Acute auricular hematoma resulting in the "cauliflower" ear has affected wrestlers from the time of the first Olympic games in ancient Greece, Doctor Charles S. Giffin of Fort Wayne, Indiana points out in the March 1985 issue of the *Archives of Otolaryngology*. Injury often occurs during a "takedown" or when the ear is rubbed in a "riding position." The result is a swollen ear that can become permanently disfigured, if not treated. Giffin describes a 12-step treatment that involves open drainage of fluids and removal of newly formed fibers and cartilage.

• • •

Neither the method of feeding nor the type of milk fed accounts for "colicky" babies, according to a report from pediatricians at the Yale University School of Medicine. The problem more likely is related to parental anxiety, note Doctor Brian W. C. Forsyth and his colleagues writing in

the March 1985 issue of the *American Journal of Diseases of Children*. They followed 189 mothers intending to breast feed and 184 intending to formula feed their infants for a four-month period. In each group, breast or bottle, 35 per cent of the mothers reported feeding problems. The researchers advise pediatricians to watch for signs of anxiety concerning feeding on the part of mothers. Counseling and reassurance can mitigate the problem, they say.

• • •

An increased frequency of fingertip loops and a concomitantly decreased frequency of whorls and arches could offer confirming evidence of Alzheimer's disease, according to a study in the January 1985 issue of the *Archives of Neurology*. Doctor Herman J. Weinreb of New York University Medical Center studied fingerprint dermatoglyphic patterns in 50 patients with presumed senile dementia of the Alzheimer type and compared them with a control group of 50 patients. Patients with Alzheimer's disease showed a "significantly increased frequency" of the patterns noted. Those patterns "are congruent with patterns repeatedly found in Down's syndrome, and support the known associations between these two diseases," Weinreb says. Similarities in brain-plaque patterns in the diseases previously have been noted.

• • •

A new service designed to help put family physicians in contact with practice opportunities has been instituted by the American Academy of Family Physicians (AAFP). The Computer-Assisted Site Selection (COMPASS) is a clearinghouse for information exchange between practice-seeking family physicians and physicians, communities, hospitals, and others who are seeking a physician to join, start, or buy a practice. The COMPASS information bank is developed through two questionnaires. One goes to family physicians to elicit information on their practice preferences. The other goes to communities to obtain information on their offering. Periodic searches will then match family physicians and practice opportunities. While the family physicians will receive the questionnaires of communities that best fit their preferences, the communities will receive background information concerning the family physicians. The family physicians and communities will then follow up directly with one another.

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The Committee handles inquiries in *complete confidence*. If you know of a physician who needs an advocate and support in obtaining necessary treatment, please call or write Dr Rakatansky c/o The Committee on Impaired Physicians, Rhode Island Medical Society, 106 Francis Street, Providence 02903 (401/331-3207).

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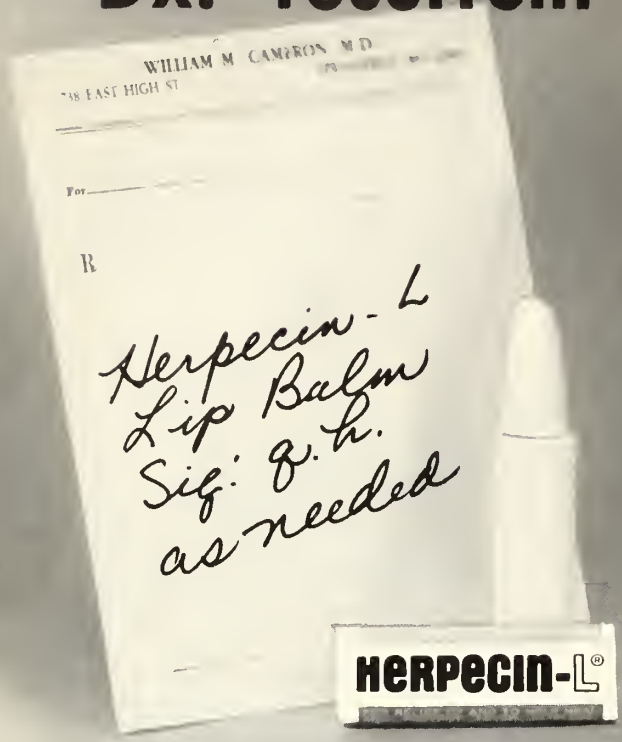
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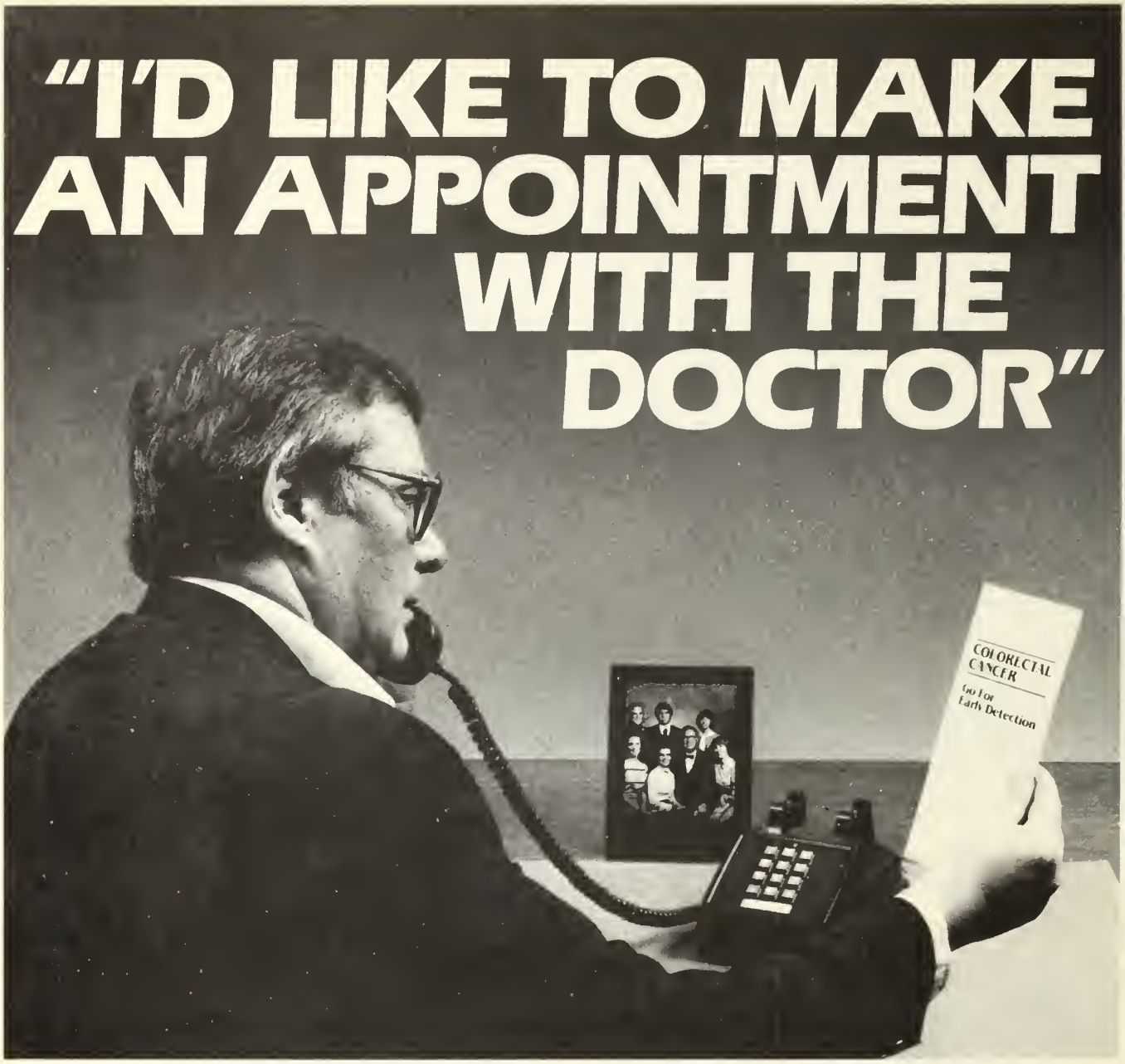
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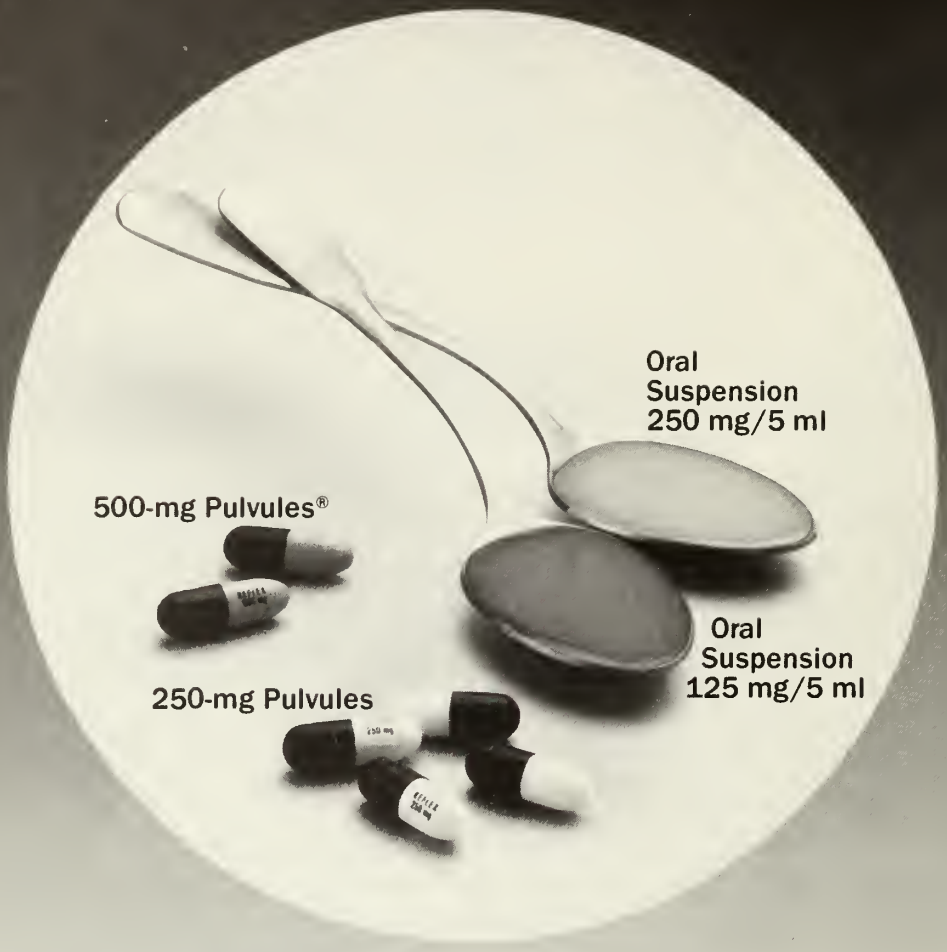
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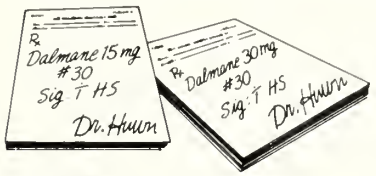
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Contraindications: Known hypersensitivity to flurazepam HCl, pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patients to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Withdrawal symptoms rarely reported; abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase, and paradoxical reactions, *e.g.* excitement, stimulation and hyperactivity.

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Rhode Island Medical Journal

February 1986
Volume 69, Number 2

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FEB 25 1986



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Before prescribing, see complete prescribing information in SK&F CO. literature or *PDR*. The following is a brief summary.

* **WARNING**

This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Contraindications: Concomitant use with other potassium-sparing agents such as spironolactone or amiloride. Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: **Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired.** If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

Precautions: The bioavailability of the hydrochlorothiazide component of 'Dyazide' is about 50% of the bioavailability of the single entity. Theoretically, a patient transferred from the single entities of Dyrenium (triamterene, SK&F CO.) and hydrochlorothiazide may show an increase in blood pressure or fluid retention. Similarly, it is also possible that the lesser hydrochlorothiazide bioavailability could lead to increased serum potassium levels. However, extensive clinical experience with 'Dyazide' suggests that these conditions have not been commonly observed in clinical practice. Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids, and during concurrent use with amphotericin B or corticosteroids or corticotropin [ACTH]). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Cumulative effects of the drug may develop in patients with impaired renal function. Thiazides should be used with caution in patients with impaired hepatic function. They can precipitate coma in patients with severe liver disease. Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic and hemolytic anemia have been reported with thiazides. Thiazides may cause manifestation of latent diabetes mellitus. The effects of oral anticoagulants may be decreased when used concurrently with hydrochlorothiazide; dosage adjustments may be necessary. Clinically insignificant reductions in arterial responsiveness to norepinephrine have been reported. Thiazides have also been shown to increase the paralyzing effect of nondepolarizing muscle relaxants such as tubocurarine. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. Triamterene has been found in renal stones in association with the other usual calculus components. Therefore, 'Dyazide' should be used with caution in patients with histories of stone formation. A few occurrences of acute renal failure have been reported in patients on 'Dyazide' when treated with indomethacin. Therefore, caution is advised in administering nonsteroidal anti-inflammatory agents with 'Dyazide'. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia is uncommon with 'Dyazide', but should it develop, corrective measures should be taken such as potassium supplementation or increased dietary intake of potassium-rich foods. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Concurrent use with chlorpropamide may increase the risk of severe hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function.

Thiazides may add to or potentiate the action of other antihypertensive drugs.

Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances; postural hypotension (may be aggravated by alcohol, barbiturates, or narcotics). Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and respiratory distress including pneumonitis and pulmonary edema, transient blurred vision, sialadenitis, and vertigo have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components. Rare incidents of acute interstitial nephritis have been reported. Impotence has been reported in a few patients on 'Dyazide', although a causal relationship has not been established.

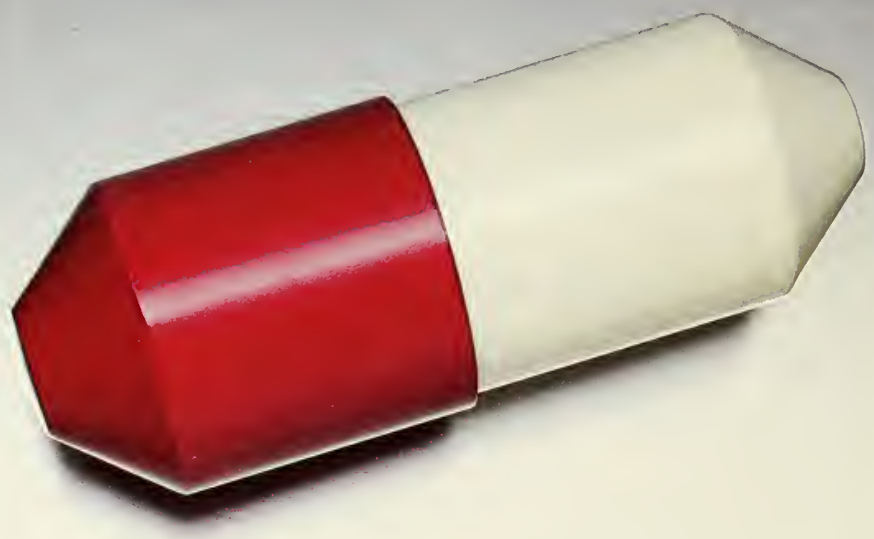
Supplied: **'Dyazide' is supplied as a red and white capsule, in bottles of 1000 capsules; Single Unit Packages (unit-dose) of 100 (intended for institutional use only); in Patient-Pak™ unit-of-use bottles of 100.**

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Newsletter

RHODE ISLAND MEDICAL SOCIETY
February 1986

Herbert Rakatansky, MD, President
Wendy J. Smith, Editor

HOUSE HEARS ABOUT MALPRACTICE

The Legislative Commission on Medical Malpractice, headed by Senator Michael Forte (D, Tiverton), has accelerated its schedule and thus far has heard testimony from physicians, attorneys, the Joint Underwriting Association, legal expert Jeffrey O'Connell from the University of Virginia, and hospitals, Doctor Paul J.M. Healey recently told the House of Delegates. Healey is one of three physicians serving on the 17-member Commission. The Commission is expected to issue majority and minority reports to the General Assembly early this spring. It was appointed by the General Assembly in 1984 in lieu of acting on a five-part malpractice reform package introduced by the Society.

Meanwhile, under the aegis of the Hospital Association of Rhode Island (HARI), a group of 17 organizations in Rhode Island has been meeting weekly to address the professional liability crisis. Included in the Rhode Island Medical Liability Coalition are representatives from the Rhode Island Medical Society, HARI, insurance companies and agents, the business community, health care purchasers, labor, and risk managers. Meetings have been held with physicians, attorneys, hospitals, insurers, and officials from the Governor's office and the Department of Business Regulation. At its January 8 meeting, the Coalition voted to endorse in concept several reform proposals, including a $250,000 cap on awards for pain and suffering, reduction of the rate and effective date for interest payments on awards, and a limitation on attorneys' contingency fees.

In other actions at its January 23 meeting, the House:

- delayed consideration of a proposed interprofessional code of relations between physicians and attorneys. Developed by a joint RIMS/Rhode Island Bar Association committee, the code represents two years of work and covers such matters as medical reports, depositions, and court testimony.

HOUSE MEETING (continued)

- tabled discussion of the Uniform Rights of the Terminally Ill Act pending action by the Legislative Commission on the Living Will. Proposed by the National Conference of Commissioners on Uniform State Laws, the bill would establish a living will mechanism for the state of Rhode Island. Previous attempts to enact living will legislation have been unsuccessful because of the opposition of the Providence Catholic Diocese.

- recommended that dues exemption be granted to physicians over age 70 upon request regardless of practice status and also to those physicians under age 70 who have retired from active practice.

- recommended that physicians who are spouses of members be allowed to join at 50 per cent of current dues.

- noted that the 1985 Fiske Fund Prize has been awarded to Doctor David F. Wehlage, Clinical Professor of Psychiatry, University of Indiana School of Medicine, for his contribution, "The Doctor-Patient Relationship: Friend or Adversary?"

- recommended to the Rhode Island Department of Health that 60 hours of Category 1 continuing medical education credit be required for the triennial licensure period November 1, 1985 to October 30, 1988.

NEW BROCHURE AVAILABLE ON MALPRACTICE

A new brochure on the professional liability crisis has been sent to all RIMS members.

Available in bulk quantities at no charge, the brochure is intended for distribution in physicians' waiting rooms or for use as bill stuffers. Emphasizing the fact that medicine is not an exact science, the brochure discusses the escalating rate of malpractice premiums, the growth of "defensive medicine," and the impact of the malpractice crisis on the cost and quality of medical care. Because "all too often, lawsuits against physicians seem to evolve from a lack of communication between patient and doctor," the pamphlet encourages patients to tell their physicians if they are not happy with the medical care they are receiving.

For further information, please call the Society's offices at 401/331-3207.

20 PER CENT OF MASSACHUSETTS DOCTORS PLAN TO RETIRE EARLY

"Whatever happens in Massachusetts, I'm sure will spill over the border into Rhode Island," Doctor Barbara Rockett, president of the Massachusetts Medical Society, told the House of Delegates at its January 23 meeting. With that comment, she proceeded to enumerate such thorny issues as the specter of rising malpractice premiums, mandatory Medicare participation, and seemingly endless liability for doctors for such intangibles as "pain and suffering."

Rockett revealed the results of a Massachusetts survey, in which 20 per cent of the 3,236 respondents said they would retire early to escape rising insurance costs. Another 17 per cent said they would curtail their activities as specialists. Eight per cent said they would leave medicine. Some 19 per cent of the respondents said they would leave Massachusetts, and according to Rockett, 22 doctors already have. Massachusetts physicians are faced with retroactive malpractice insurance increases that could range as high as $31,600 per physician to help finance the commonwealth's bankrupt Joint Underwriting Association.

Another drastic situation in Massachusetts involves Medicare. The commonwealth recently enacted a law requiring that as a condition of granting or renewing a license to practice medicine, a physician must agree to accept the Medicare assignment as payment in full for treating Medicare beneficiaries. The constitutionality of the law is being challenged in a lawsuit recently filed by the American Medical Association and the Massachusetts Medical Society.

Rockett suggested several courses of action, including more active involvement by physicians with legislators, patients, the public, and the media. She also recommended forming coalitions with other groups adversely affected by rising liability costs.

RIMS OBJECTS TO JUA SURCHARGE

The Rhode Island Medical Society recently objected to a proposed regulation which would levy a 50 per cent surcharge on all initial policies underwritten by the Joint Underwriting Association (JUA) and a 16 per cent increase in all renewals. The mandatory contribution would be allocated to the JUA's stabilization reserve fund.

Pointing out the deleterious impact of the surcharge on all physicians establishing practices within the state, Doctor Herbert Rakatansky, RIMS President, said the negative results would be felt at a time when the rate of growth of the physician population is the lowest of all 50 states. During the period 1980-1983, the rate of growth was 5.7 per cent in contrast to Massachusetts (10.8 per cent), Maine (12 per cent), Connecticut (10.5 per cent), New Hampshire (14.6 per cent), and Vermont (9.8 per cent). In addition, Rhode Island has 222 physicians/100,000 population while the New England average is 287/100,000.

Moreover, the proposed increase in the man-

JUA INCREASE OPPOSED (continued)

datory contribution to the stabilization reserve fund for renewals will "most certainly have a negative and perhaps decisive influence on doctors who are considering retirement," Rakatansky said. Approximately 39 per cent of the 1,821 physicians engaged in the practice of medicine as of December 31, 1983 were 55 years or older.

One equitable solution to the JUA deficit problem, he suggested, would be to limit the liability of physicians to economic losses and to fund awards for pain and suffering either through a surcharge on all health insurance policies or through a requirement that individuals be offered the option of this extra coverage at their expense.

PHYSICIANS MUST BUY MEDICARE FORMS

The Health Care Financing Administration (HCFA) has published two regulations in the Federal Register that now require physicians to purchase the AMA Health Insurance Claim Form for filing Medicare and Medicaid claims. A cost-savings measure published September 30 directed Medicare carriers to stop distributing the HCFA-1500 form free to physicians and other providers, effective October 30. Under the new regulations, all providers will be required to purchase the AMA Health

MEDICARE FORMS (continued)

Insurance Claim form in single sheets or a continuous-feed format. In another new regulation issued October 7, HCFA directed state Medicaid management information systems to use the AMA Health Insurance Form for physician services, effective October 1, 1986.

To obtain an order form, or to purchase the claim forms, write to AMA Insurance Form, Book and Pamphlet Fulfillment, PO Box 10946, Chicago, Illinois 60610. The telephone number is 312/280-7168.

CLAIMS AGAINST OB/GYNs CONTINUE TO MOUNT

There has been a significant increase in the number of claims filed against obstetricians and gynecologists, a recent American College of Obstetricians and Gynecologists survey shows. Almost three-fourths of the respondents reported that they had claims filed against them, compared with two-thirds in 1983. Of the obstetricians-gynecologists faced with lawsuits, three-fourths settled the cases and one-fourth contested the cases in court. Of the latter group, 15 per cent said they lost the case.

The results were based on a national survey of more than 1,400 obstetricians-gynecologists.

PRACTICE MANAGEMENT QUESTION OF THE MONTH:

MEDICARE PAYMENT DENIALS

Two recent announcements by the Health Care Financing Administration (HCFA) provide a clear idea of the actions which local peer review organizations are likely to scrutinize. Specifically, in August HCFA issued its PRO Manual guidelines concerning review of admissions, transfers, and discharges. In November HCFA promulgated a revised "scope of work" for all renewed PRO contracts. These two documents emphasize sensitive areas for physicians and other providers under the prospective payment system.

The PRO manual lists four types of actions which will automatically cause the PRO to deny payment for a readmission or transfer of Medicare patients. The provider will be liable for the full costs of treatment provided in the subsequent hospitali-

zation. The patient may not be billed for these costs.

Premature discharge and subsequent readmission of the patient: Whenever a patient is readmitted to the hospital within 15 days, the PRO is directed to review hospital records of the first admission to determine whether a patient "should have remained in the hospital for further treatment or testing" or whether the patient "was not medically stable at the time of discharge." Factors which the PRO will evaluate in determining whether a discharge was premature include elevated temperature, post-operative wound discharge or bleeding, or abnormal laboratory results on the day of discharge.

Readmission for treatment which could have been provided during the first admission: Even if a patient was medically stable at the time of admission, the PRO will deny payment for a readmission of care that should have been provided during the first hospitalization.

Inappropriate transfer of a patient from a prospective payment unit of a hospital to a reasonable cost unit of the same hospital: The DRG payment system does not apply to qualifying psychiatric and rehabilitation units of a hospital. It also does not apply to skilled nursing facilities which may be operated by the hospital. These "exempt units" are reimbursed on a reasonable cost basis.

The PRO will review the medical records of patients who are transferred into an exempt unit to determine whether the patient initially required care in an exempt unit and whether a bed was available in the exempt unit at the time of admission. If so, the PRO will deny payment for admission to the DRG unit of the hospital. This category relates only to transfers between units of the same hospital. It does not apply to transfers from a DRG hospital to another DRG hospital or to a reasonable cost facility which is not affiliated with the transferring hospital.

Inappropriate transfer of a patient from a reasonable cost unit of a hospital to a prospective payment unit of the same hospital: This category is the reverse of the previous one. The PRO will deny payment for transfers from an exempt unit to a prospective payment unit when the patient does not require the level of care provided in the acute care portion of the hospital. Like the third category, this one applies only to transfers between units of the same hospital. It does not apply to transfers from units which are not affiliated with the transferring hospital.

Generally, a PRO is supposed to review a randomly-selected 2.5 per cent of cases. In addition, the proposed "scope of work" for PRO contract renewals lists several practices and procedures which may be scrutinized more frequently. These include:

- Elective admissions which result in a one- or two-day hospitalization
- Cases in which the length of stay is substantially lower than the average length of stay for a particular DRG
- Transfers from a covered hospital to another hospital
- Admissions or transfers to a substance abuse unit, psychiatric unit, rehabilitation unit, or swing bed
- Outliers
- Admissions to an exempt unit that involve covered care after admission
- Permanent cardiac pacemaker implantation or reimplantation

Rhode Island Medical Journal

February 1986

Volume 69, Number 2

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Rhode Island Medical Journal is owned and published by the Rhode Island Medical Society, 106 Francis Street, Providence, Rhode Island 02903, Ph: 401/331-3207. Single copies $2.00 — Subscriptions $15.00 per year (members of the Rhode Island Medical Society — $5.00 annually). Published articles represent opinions of the authors and do not necessarily reflect the official policy of the Rhode Island Medical Society unless clearly specified. Advertisements do not imply sponsorship or endorsement by the Rhode Island Medical Society. Second class postage paid at Providence, Rhode Island and at additional mailing offices. **ISSN 0363-7913**



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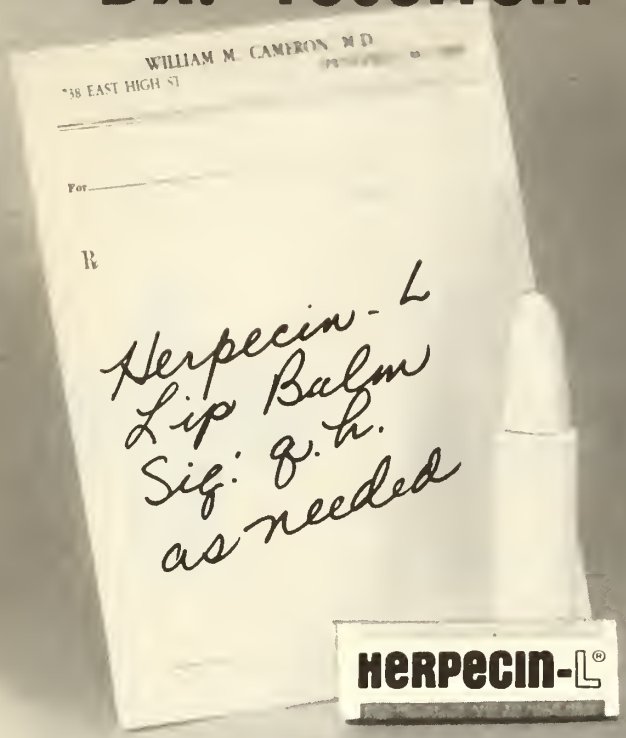
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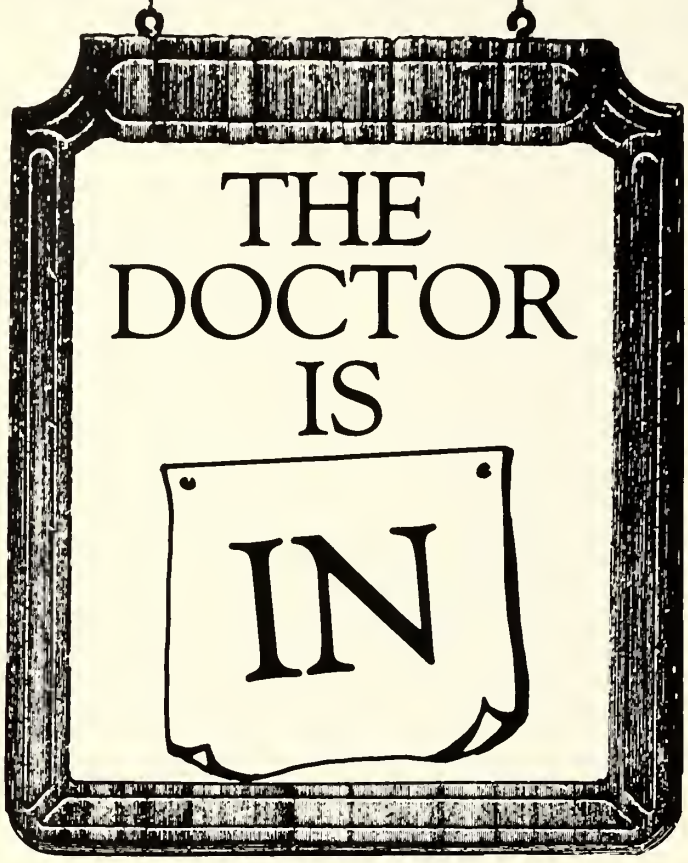
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EDITORIAL

Commitment to the Elderly

Rhode Island physicians can be proud of their commitment to the elderly, and specificially to the Medicare beneficiaries of the state. Since its inception in 1965, Rhode Island physicians have participated in the Medicare program in record numbers. In 1983, eighty-nine per cent of all Medicare Part B claims in Rhode Island were voluntarily accepted on assignment. This gave Rhode Island the distinction of having the highest rate of assigned claims among all states, at a time when the national average for assignment under Medicare was only 50 per cent of claims. For the elderly patient, this voluntary commitment to accept assignment under Medicare meant that there were no unforeseen financial burdens. The physician handled the paperwork and accepted 80 per cent of the Medicare prevailing charge from the carrier. The patient paid the 20 per cent copayment. Out-of-pocket costs to the elderly, though still seen as a problem, have been minimized. This is due both to the acceptance of assignment and the fact that more than 75 per cent of elderly persons have some form of supplemental insurance (such as Blue Shield Plan B) which covers copayments and deductibles.

Since 1983 the rules of participation in Medicare have changed. Participation means that the physician must accept the Medicare payment as payment in full all the time. Physicians who do not participate in Medicare can decide on a case-by-case basis whether or not to accept the Medicare payment as payment in full. Those who participate in the program will have their customary and prevailing charge levels updated while non-participating physicians will have billed charges frozen at June 1984 levels.

It has been estimated that 46 per cent of Rhode Island physicians participate in Medicare, ie, they accept all claims on assignment. This figure can be misleading. Non-participating physicians can also accept claims on assignment. According to the fiscal intermediary, in 1985 between 85 and 90 per cent of Medicare claims were accepted on assignment by Rhode Island physicians. This indicates that both participating physicians, those who have agreed to accept assignment all of the time, and non-participating physicians, those who decide on a case-by-case basis, have continued to serve the elderly.

Before the enactment of Medicare legislation in 1965, the elderly had less access to hospital and physician services than the general population. This lesser access to medical care existed despite the fact that the elderly suffer a disproportionate amount of illness and disability. Medicare completely revolutionized over a very short period of time the availability of medical care to the elderly. As a result of Medicare, the hospital and physician utilization rates of the elderly rose above the averages for the general population, reflecting their greater health care needs. We can all be proud of the national concern for the elderly which Medicare represents. We can also be proud of the fact that our own late United States Representative Aime J. Forand was one of the founding fathers of Medicare.

It is now our challenge both as physicians and citizens to preserve the commitment to the elderly which Medicare forged. I am confident that Rhode Island physicians will continue to serve as exemplars in this important arena of public health policy.

H. Denman Scott, MD
Director
Rhode Island Department of Health

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PRESIDENT'S PAGE

A "Mini-Residency" for State Officials

One of the truths of medicine as it is practiced today is the presence of third parties which intrude on the traditional doctor-patient relationship. There may be insurance payers, government regulatory agencies, and legislative bodies among others. From the physician's viewpoint, persons involved in such activities may seem to ignore important parts of the health care delivery system and rely on only statistical and abstract data in making decisions. On January 10 and 11, the Rhode Island Medical Society took a small step to change this situation. On those dates the medical society sponsored a "mini-residency" for members of the legislature, health department, and others.

The program took place at the Memorial Hospital in Pawtucket under the direction of Doctor Richard A. Carleton, physician-in-chief. After an initial welcome at 7 am, the participants were divided into small groups and assigned to a team of residents making morning rounds. Accompanying each group was a senior physician who acted as an "interpreter" to explain to the guests the details so that the rounds could proceed efficiently. Following rounds the guests attended residents' report in the department of medicine.

After a short break for coffee, they moved on to a regularly scheduled ethics conference. At this conference a person with severe chronic lung disease who was respirator dependent was presented. Issues discussed included whether the patient had a right to ask for the respirator to be disconnected; whether she could have decided prior to intubation to refuse the procedure; and, if she remained on the respirator, who would bear the financial responsibility and in which facility could she be supported on a chronic basis.



It became apparent that there was no good answer to any of these questions. The guests actually participated in the discussion and learned about these problems first hand. Lunch followed, and then information was presented by the hospital administration about credentialing and the formal mechanisms of quality assurance.

Three cases were then presented to the group on location. First they visited the emergency room where the ER staff presented a case and discussed it. Then all moved to the intensive care unit (ICU) where a case of an elderly woman with a fractured hip was presented. She required a Clinitron bed to prevent decubitus ulcers; the problem of the expense of such care as well as its unavailability in the nursing home setting made a profound impact.

The obstetrics unit was the final stop on this odyssey. The case presentation there revolved around issues of Caesarian sections and the malpractice risks for obstetricians. In all of these case discussions emphasis was given to social and societal problems.

The afternoon ended with attendance at a surgical morbidity and mortality conference. The process of reviewing all complications of deaths was a revelation to the guests. The frankness of the discussion and the willingness to identify

problems so that they are not repeated was a surprise. The clamor from the public for increased peer review might be less if the true story of the operation of the medical system were more widely known.

After supper with the residents, the guests were assigned into small groups and again with a senior physician acting as an "interpreter," they accompanied either the ER residents, the medical admitting resident, or the ICU resident.

Finally at 9 pm everyone was dismissed with a homework assignment. Each participant was to select one case he or she had seen and consider it in terms of the following issues: ethics, medical decisions, malpractice, cost, and quality assurance. In each category a proposed solution was requested for any perceived problem.

We met again at 8 am the following morning and each participant presented his or her views on the selected case, and all had the chance to comment. The participants were impressed with the quality of care and the caring manner in which it was delivered. They were uniformly impressed with the close relationship they observed between the doctor and the patient. We observed that even in one day the participants themselves had become involved with the patients and had more than a passing interest in their outcomes. They agreed that they had. Is there a better way to teach the facts to the lawmakers and the regulation writers than to allow them to feel these emotions? I don't think so and, interestingly, neither do they.

Ethical problems were freely discussed, and the participants understood the benefits of passing a "living will" law in Rhode Island. The issue of third party intervention and the possible effect on quality was also a heated topic. The role of the doctor as the patient's advocate and his or her obligation to obtain the best possible diagnosis and treatment was emphasized. As an intellectual exercise, this subject is quite dry and academic. When discussed in relation to a specific patient whose outcome is uncertain, the discussion assumes a remarkably different perspective.

By the end of the whole experience the patients had acquired another set of advocates in addition to their physicians. The participants themselves understood the role of the doctor and his or her obligations in a manner impossible to duplicate in a didactic session. This was recognized by both those conducting the session and the participants themselves.

The group started with five legislators and one person from the health department along with four others. Several dropped out during the day because of personal obligations. Three members of the malpractice commission attended, two of whom participated in the entire two-day session.

Whether this kind of experience will change the climate affecting medical affairs in a substantive way is not clear. Certainly it has provided new insights for those attending. I suggest that this be an annual event sponsored by the Rhode Island Medical Society. By presenting the truth about medical care in a personal manner to those who are involved in the delivery care system in a regulatory role, our patients can only win.

A Statewide Motor Vehicle Injury Surveillance System

Emergency Room Vehicular Injury Cases Are Heavily Weighted toward Adolescents, Younger Adults, and Males

Ian Rockett, PhD
William H. Hollinshead, MD, MPH
Ellice Lieberman, MD, MPH

In Rhode Island, as for the United States as a whole, motor vehicle "accidents" are the leading cause of injury-related fatalities. Data for the period 1980-1982 indicate that they accounted for 27 per cent of all such deaths.[1] Moreover, since victims are disaproportionately younger people, motor vehicle accidents represent the "greatest single etiologic factor in potential years of life lost."[2]

In acknowledging that the road toll must be measured through morbidity as well as mortality, the Rhode Island Department of Health has established a hospital emergency room surveillance system. It is the only statewide population-based system of its kind in the nation. It incorporates all twelve non-psychiatric, acute care hospitals in Rhode Island which have an emergency room facility. In addition to its powerful descriptive potential, the system will enable the incidence and severity of motor vehicle injuries to be analyzed in relation to such factors as the recent change in the minimum legal drinking age and an anticipated mandatory seat-belt law.

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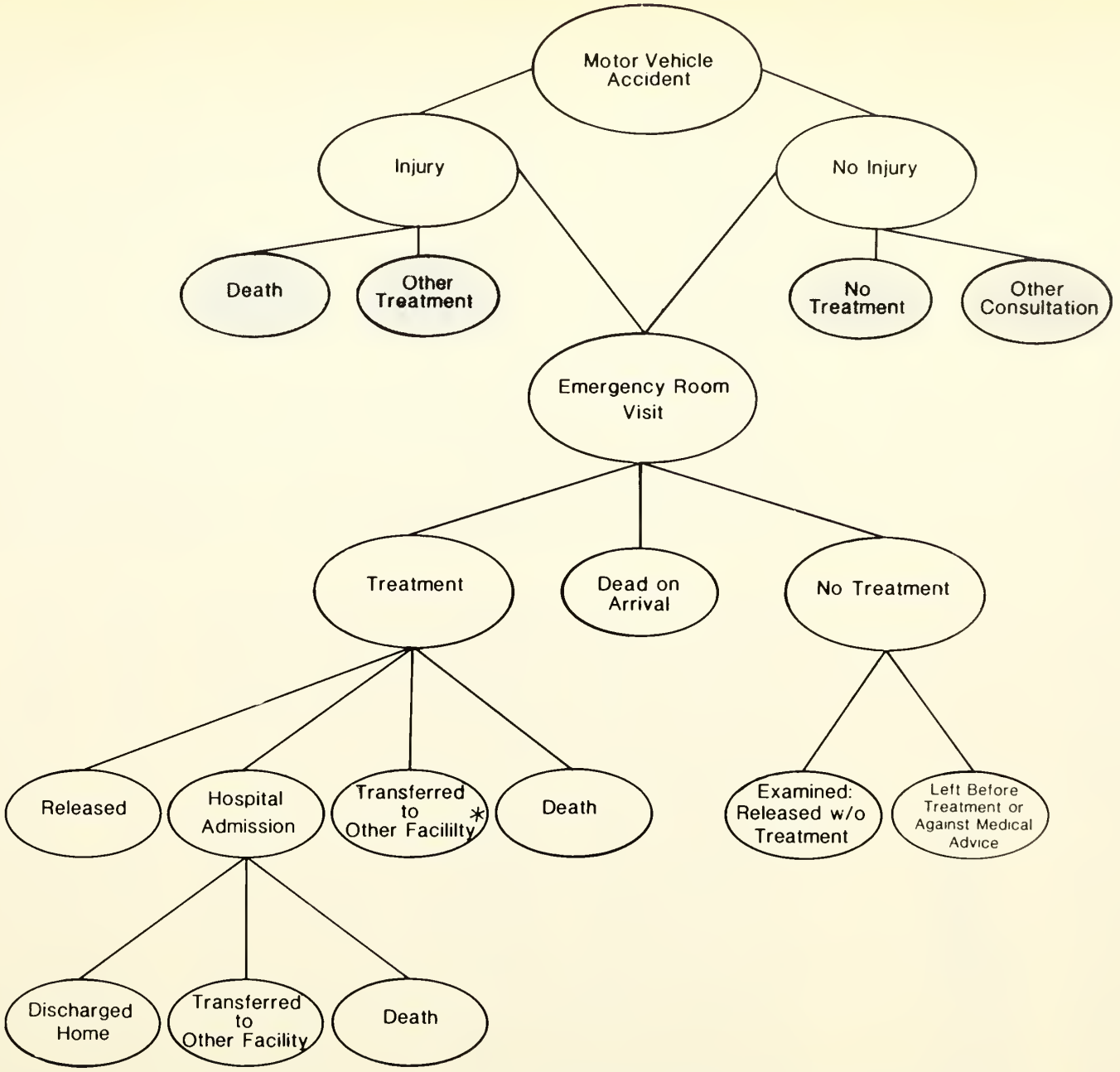
The primary purpose of this paper is to outline the scope and the underlying methodology of the surveillance system. Also included is a preliminary description of the basic demographic characteristics of the emergency room population in comparison with those of the Rhode Island population as a whole.

Methodology

Sample population: A 25 per cent sample is being drawn from all motor vehicle accident patients presenting at hospital emergency rooms in Rhode Island during calendar years 1984 and 1985. To this end, data are being abstracted from all pertinent records every fourth week. This abstraction sequence has been designed to prevent over- or under-reporting of major holiday periods that would be expected to be associated with fluctuating injury rates. It further circumvents similar problems of seasonal variations.

Case-finding and data abstraction: In two of the participating hospitals, case-finding is initiated through reference to daily emergency room log sheets. Since these hospitals originally did not routinely identify motor vehicle accident cases, arrangements have been instituted to have all new cases flagged in the log. In the remaining hospitals case-finding starts with the emergency room record itself. Abstraction is performed by a medical records technician, who records the data on a standardized form. Each case is followed through to emergency room release, hospital discharge, or death. Cases transferred to other hospitals in the system are also followed.

Figure 1: A Motor Vehicle Injury Emergency Room Surveillance System: Patient Pathways



* If the receiving facility is included in the surveillance system, transfer patients are followed for all outcomes.

☐ Outside the purview of the surveillance system.

Table 1. Percentage Age Distribution of Emergency Room Patients and Rhode Island Population by Sex

	Emergency Room			Rhode Island		
	Males	Females	Total	Males	Females	Total
0-14	9.4	9.0	9.2	21.8	19.0	20.3
15-29	55.4	47.2	52.3	28.1	26.1	27.1
30-44	18.8	28.3	22.4	18.3	17.3	17.8
45-59	8.5	11.3	9.5	16.1	16.3	16.2
60-74	5.0	3.3	4.4	11.9	14.4	13.2
75+	2.1	0.9	1.7	3.8	6.9	5.4
Unknown	0.9	—	0.5	—	—	—
TOTAL	100.1 (341)	100.0 (212)	100.0	100.0 (451,251)	100.0 (495,903)	100.0

Quality control: Prior to starting data abstraction, technicians undergo training with a medical consultant. Once in the field they attend periodic problem-solving sessions with the consultant and other team members. Whenever necessary, original records are retrieved and reexamined. Further quality control procedures include visual scanning of completed surveillance forms, use of a coding manual and a current decision book, validation of a five per cent random sample of cases, verification through double data entry, and routine computer checks of internal consistency.

Table 2. Sex Ratios for Emergency Room Patients and the Rhode Island Population by Age

Age	Emergency Room	Rhode Island
0-14	168	105
15-29	189	98
30-44	107	96
45-59	121	90
60-74	243	76
75+	350	49
TOTAL	161	91

Variables

For each emergency room case in the surveillance system sample, data are compiled on 48 variables. They may be categorized broadly as follows:

Sociodemographic background: Variables covered under this rubric are patient age, sex, marital status, ethnicity, religious affiliation, and residential census tract. The last of these serves as the basis for inferring socioeconomic status.

Injury specifics: Patient injuries are classified by external cause (E code) and diagnosis (N code) in accordance with the ninth revision of the *International Classification of Diseases, Clinical Modification (ICD-9-CM).*[3] Provision is made for a four-digit classification and up to six diagnoses. Ultimately, diagnostic codes will be converted into severity scores.

Date and time of both injury and emergency room visit are recorded, as is means of arrival. Also of concern is whether the patient lost consciousness during the accident, and whether there is evidence of concomitant illness, alcohol, or other drug use.

Accident circumstances: To shed light on the circumstances precipitating the emergency room visit, information is recorded on a wide range of patient and accident-related characteristics. These include whether the patient was a pedestrian, a motor vehicle driver, or a passenger. In cases where patients were automobile occupants at the time of the accident, efforts are made to ascertain seating position and the use of seat belts. Similarly, information is sought on the helmet status of patients whose accident occurred on a motorcycle, moped, or bicycle.

Case disposition: This category embraces the disposition of each case from the emergency room and where relevant, the nature of hospital admission, disposition, and duration of stay, including that in an intensive care unit.

Scope and Limitations

The scope and limitations of the surveillance system are illustrated in Figure 1. Since the system is population-based, it has the capacity to generate injury incidence rates and not merely case counts. This is extremely valuable, both for comparative

purposes, and for designing, targeting, and evaluating injury countermeasures.

Omitted from the system are those individuals involved in motor vehicle accidents who do not enter an emergency room of any of the designated hospitals. The omissions include those who refrain from seeking treatment or are self-treated and those whose treatment occurs in an HMO, a freestanding clinic, a military facility, or in the office of a physician, dentist, or chiropractor. As these injury cases are on average likely to be less serious than those seen in the emergency room, their omission will lead to an underestimation of less severe injuries as compared to those more severe injuries necessitating hospitalization.

Also omitted from the surveillance system are people who die and are not taken to an emergency facility in the system. However, these deaths are documented by the Office of the Medical Examiner and will be incorporated in certain analyses.

Inter-hospital variation in reporting practices precludes complete data collection on all cases comprising the study population. The initial batch of data suggests, for example, that blood alcohol levels are rarely taken. Patient race is also poorly recorded. Documentation of reporting deficiencies should facilitate effective promotion of comprehensive uniform data collection in Rhode Island hospital emergency rooms. This in turn would greatly enhance injury surveillance, as would the routine assignment of an appropriate E code to all injury cases seen in the emergency rooms.

Preliminary Population Profile

The following comparative demographic profile is based upon the first batch of emergency room data to be collected and processed, and on the Rhode Island population as enumerated during the 1980 United States census. Data have been compiled on 553 emergency room patients.

With the Rhode Island population serving as the yardstick, emergency room patients are found to be highly selective by age (Table 1). Over half fall into the 15 to 29 age group, and nearly 85 per cent are under 45 years of age. The corresponding Rhode Island figures are 27 per cent and 65 per cent. Both males and females in the 15 to 29 age group are grossly overrepresented among emergency room patients when compared to their respective proportions in the overall state population. Females aged 30 to 44 are also overrepresented. Irrespective of sex, however, all remaining age groups are underrepresented.

Reference to the overall sex ratios, which are expressed as the number of males per 100 females, indicates that emergency room patients are also highly selective by sex (Table 2). These patients manifest a 60 per cent excess of males. By contrast, there is a 9 per cent deficit in the Rhode Island population. In fact, a male deficit is evident in that population for all age groups, except that aged zero to 14 years. There is also an inverse relationship between the size of the sex ratio and age. Among emergency room patients, a male excess is evident at all ages. Their age-specific sex ratios actually bottom out at ages 30 through 44 years, but thereafter rise sharply.

Since the emergency room data are preliminary, any conclusions must be speculative. The data strongly suggest, however, that motor vehicle accident cases presenting at Rhode Island hospital emergency rooms are not proportionally representative of the state population with respect to either age or sex. Such cases seem heavily weighted with adolescents and younger adults. Moreover, an excess of males is apparent across the entire age spectrum.

Acknowledgments

The authors wish to thank Sandra Putnam, Joan Freitas, and John Migotsky for their technical assistance. This research is supported by the National Highway Traffic Safety Administration (DTNH 22-81-C-05026).

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75 Davis Street
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Management of the Emergency Department in a Community Hospital

Separation of Patients Suitable for Rapid Disposition from Those Requiring Work-up Facilitates Emergency Room Operations

H. Gerald Rock, MD
Katherine Whalen, RN

The emergency department of a large hospital plays an increasingly active role in the development of hospital business. A certain percentage of all patients who enter hospital emergency departments will become inpatients. It follows that an attractive, well-staffed emergency department with a short waiting period will attract more and more patients to the hospital. While there are very few complaints about the quality of care in emergency departments, there are always many complaints about the length of time patients wait to be treated.

This problem has stimulated across the country the emergence of freestanding so-called emergency rooms. While the quality of care in these emergency rooms may at times be questionable, the public still utilizes them because the service is fast.

Two-Track Triage

At Kent County Memorial Hospital we have attempted to address this problem in a way that maintains a high quality of care with a shorter waiting period for the patient by developing a separate pathway for patients with relatively minor injuries. During the busy part of the day, two triage nurses determine if patients have injuries or complaints which would qualify them to be placed in the rapid treatment area, designated as the express unit. The triage nurses use as a guideline some fourteen diagnoses which include sprains of the distal extremities, sore throats, minor abrasions, contusions, insect stings, poison ivy, embedded fish hooks, foreign bodies in the eye, toothaches, minor lacerations in adults and children over four years of age, splinters, swimmers' ear, subluxation of the radial head, minor burns, and obvious cystitis. Patients who will require extensive laboratory work, x-ray studies, consultation with a specialist, or a workup for more complicated illnesses are not sent through the express unit, but are sent to the regular emergency department.

We have found that it is necessary to have a separate waiting room for the express patients. People who are waiting for treatment of more serious illnesses frequently become incensed if the patients with minor injuries are treated before them. In the express area, the receptionist registers the patient, using a separate computer station, and the patient is brought directly to a five-bed treatment unit. This unit is staffed by a full-time physician, a registered nurse, and a licensed practical nurse or a technician. If patients require prompt x-ray films, as in the case of a sprain, they can be sent from this unit to the x-ray department. In general, our purpose is to eliminate from the mainstream of emergency care those persons who require very little in the way of laboratory testing or even physician attention.

To date, this program has been an unqualified

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Katherine Whalen, RN, is Director of Emergency Service, Kent County Memorial Hospital, Warwick, Rhode Island.

success. Patient acceptance of the program is excellent. The physicians and nurses who work in this area find it pleasurable to care for patients when they are neither rushed nor harried and where the patient has not waited for a few hours to be seen. The unexpected bonus of this system is that the number of persons treated in the main emergency department has been reduced by one-third. This means that the pace in the main emergency department is slower, and the patients receive more deliberate care. The waiting time in this part of the department has been decreased substantially. Prior to the establishment of the express area, patients waited an average of two hours to be treated, with the times ranging from forty-five minutes to five hours. Since the inception of the express unit, the patients in the regular emergency department are discharged in an average of one-and-one-half hours. The patients in the express unit, from time of entry to time of discharge, stay for an average of less than forty minutes.

Criteria

We believe that if the express unit is to be a success, certain standards must be met. First, selection of the patient for the express area must be made as soon as the patient arrives in the emergency department. Second, the patient has to wait in an area which is separate from the regular emergency department waiting room. Third, emergency department physicians, nurses, and orderlies should be designated for the express area and have this as their sole responsibility. Fourth, only minimal laboratory and x-ray work can be allowed. If the patient's illness is serious enough to require consultation from a specialist, the patient does not qualify for the express unit.

Another bonus for the emergency department is the acceptance by the public and the media. Since the merchandising of the emergency department, like all other hospital functions, is a necessary part of survival, we were pleased to have received coverage on two local television stations and to have prompted front-page articles in three local newspapers. We also have taken out advertisements in the local newspapers to publicize the service.

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It is rarely desirable to include a complete review of the literature in the references. An alphabetized bibliography is to be used only when the listing is of books suggested for supplementary reading.

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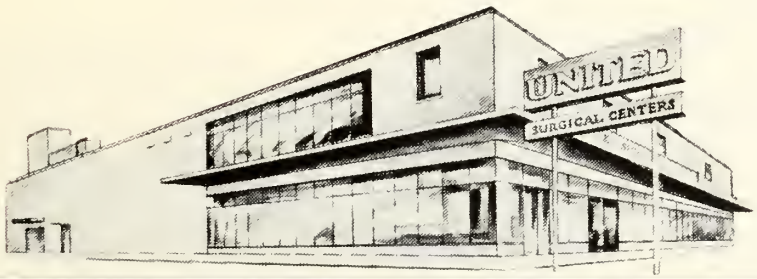
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Clinicopathological Case

Case Record: Rhode Island Hospital

Tom J. Wachtel, MD
George F. Meissner, MD
David O. Williams, MD, Editors

Case Presentation
Michael Linenberger, MD*: The patient was a 56-year-old white female missionary nun transferred to Rhode Island Hospital with pneumococcal sepsis.

She was feeling well until the day of admission to another hospital when she developed generalized weakness and nausea. On admission her temperature was 105°F. She was delirious and spoke only Spanish. She had a history of hypothyroidism, total abdominal hysterectomy and bilateral salpingo-oophorectomy (done for a class IV Pap smear), and pyelonephritis. One year prior to admission, while working in Liberia, she developed right hip and back pain, myalgias, and arthralgias. She was treated empirically with chloroquine, which was discontinued when she developed a fever and rash. She also experienced edema and abdominal distention treated with diuretics and a sulfa drug.

Two months prior to admission, she was hospitalized in Connecticut with fever, a macular rash on the neck, a vesicular rash in the groin region, and pancytopenia. Her work-up included multiple negative malaria smears, VDRL, and viral and toxoplasma titers; the erythrocyte sedimentation rate was 26 mm/hour and skin testing revealed anergy. A bone marrow aspirate revealed erythroid hyperplasia, increased megakaryocytes, myeloid series shifted to the left, and decreased iron stores. Antinuclear antibody titer was 1:640 speckled pattern; rheumatoid factor was 1:40. Culture of the vesicular groin lesions grew out *Pseudomonas aeruginosa,* and the patient improved on gentamicin with normalization of her blood counts.

* Resident, Department of Medicine, Rhode Island Hospital

At the time of admission to the other hospital, her lungs were clear to auscultation. The cardiac examination revealed a Grade II/VI systolic murmur without a gallop. The abdominal examination was initially unremarkable without organomegaly, and there were no lateralizing or focal neurologic deficits. No skin lesions were observed.

Laboratory data on admission revealed a hemoglobin of 12.6 g/dL, hematocrit 37 per cent, white blood count 10,400 with 74 per cent polymorphonuclear leukocytes, 17 per cent bandforms, 9 per cent lymphocytes, and "adequate" platelet estimated. Urinalysis and electrolytes were normal. Malaria smears showed no parasites. glucose was 118 mg/dL, and liver function tests were normal. Malaria smears shows no parasites. Her initial cerebrospinal fluid revealed a glucose of 68 mg/dL, protein of 37 mg/dL, and no white blood cells. The spinal fluid gram stain was negative. A sputum gram stain revealed epithelial cells and rare gram positive cocci in pairs. No pulmonary infiltate was noted on the chest x-ray film. An electrocardiogram revealed nonspecific ST-T wave changes.

She was treated initially with penicillin and gentamicin. This coverage was broadened with cefotaxime, metronidazole, and erythromycin when the patient developed a distended, tender abdomen on the day of admission. She became hypotensive within 12 hours of admission and was treated with volume expanders and vasopressors. On the second hospital day, the patient was placed on a mechanical ventilator because of hypoventilation. Pulmonary artery and pulmonary capillary wedge pressures were low. Blood, sputum, and spinal fluid cultures all grew *Strepto-*

coccus pneumoniae sensitive to penicillin and ultimately identified as Type 25. The patient became comatose the following day with absent respirations and a flaccid right side. Dexamethasone was given. A repeat lumbar puncture was similar to the previous examination. She was successfully weaned off vasopressors, but continued to be febrile and the white blood count increased to 59,000. The platelet count dropped and clotting studies indicated disseminated intravascular coagulation (DIC). The patient became oliguric as the blood urea nitrogen and creatinine rose to 74 and 6.3 mg/dL respectively. On the fourth hospital day she was clinically unchanged and was transferred to Rhode Island Hospital for further management and hemodialysis.

On admission to Rhode Island Hospital, the blood pressure was 104/60 (off pressors), pulse was 120, temperature was 102° rectally. She was mechanically ventilated without spontaneous respirations. The chest examination revealed diffuse rhonchi, and the heart was tachycardic without audible gallop or murmur. The abdomen was distended, tender to palpation with guarding in both lower quadrants, and without bowel sounds. She was responsive only to deep pain with a facial grimace; oculocephalic reflexes were absent, corneal reflexes were present, and pupils were initially responsive to light. There were no spontaneous movements while deep tendon reflexes were 2+ and symmetric with flexed plantar reflexes.

The chest x-ray examination revealed bilateral patchy densities more prominent in the right upper lung, suggesting asymmetric edema or pneumonia. Abdominal x-ray films suggested the presence of ascites without free air. A cranial computed tomgraphic (CT) scan without contrast revealed no hemorrhage or mass effect. Hemoglobin was 10.3 g/dL, hematocrit 31.4 per cent, white blood count 49,100, with 86 per cent polymorphonuclear leukocytes, one per cent bandforms, five per cent lymphocytes, seven percent monocytes, and one per cent myelocytes, and platelet count 74,000; a smear showed toxic granulations, vacuoles, Dohle bodies, Howell Jolly bodies, fragmented cells, and basophilic stippling. Prothrombin activity was 18 per cent, partial thromboplastin time 64.7 seconds with control 30.0, and fibrinogen 100 mg/dL with increased fibrin split products. Urinalysis revealed 11-20 red blood cells and 5-10 white blood cells per high powered field with a trace of protein. Rheumatoid factor was 62.8 IU/mL (normal less than 60 IU/mL) and antinuclear antibody titer 1:32 speckled pattern. Multiple blood and peritoneal fluid cultures were sterile.

The patient was given intravenous penicillin G 2 million units every six hours and underwent exploratory laparotomy shortly after the transfer. This revealed serous ascites with a fibrinous peritoneal exudate. The liver was enlarged, soft, and mottled. There was no cholelithiasis or evidence of perforated viscus. Postoperatively, the patient received one dose of gentamycin 100 mg and clindamycin 300 mg every six hours in addition to the penicillin. She deteriorated clinically over the next 24 hours and expired.

Clinical Discussion

Penelope H. Dennehy†: The patient is a 56-year-old missionary nun who presented with pneumococcal sepsis. Her history is complicated by the fact that she had lived in Liberia in West Africa until a few months prior to admission. She also had an illness two months prior to admission which was consistent with a connective tissue disorder.

Let us first turn to the presenting problem, pneumococcal sepsis. The patient presented no prodrome. She deteriorated rapidly, developed disseminated intravascular coagulation (DIC), and an "acute abdomen," but laparotomy did not reveal any major abdominal catastrophe. She grew out *Pneumococcus* Type 25 from blood, cerebrospinal fluid, and sputum. This type is quite unusual in the United States, making up only 0.5 per cent of total isolates, but is a common cause of bacteremia and pneumonia in Africa.[1] It is included in pneumococcal vaccine. Why did this patient develop such overwhelming and fulminant disease with this organism? What mechanisms do normal hosts have to defend themselves against pneumococcus and what defects predispose to disease? The pneumococcus is an extracellular pathogen and is destroyed primarily by phagocytosis. Each component in the phagocytic system (antibody, C3b-dependent opsonization, and the process of ingestion) must function at its best to protect fully against this organism. Defects in the host system that predispose to pneumococcal infection can be divided into three categories. First are structural defects; an example is a skull fracture with a meningeal leak which predisposes to pneumococcal meningitis. Second are defects of phagocytic function, especially neutropenia and hyposplenia. Finally, defects in humoral immunity, especially hypogammaglobulinemia and C_2 and C_3 complement deficien-

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cies, predispose to pneumococcal disease. There is an extensive list of illnesses that can lead to either defects in antibody production, opsonization, or ingestion and thus result in pneumococcal disease.[2]

This patient has no evidence for a structural cause of pneumococcal disease. We do not know about her humoral immune status, but it seems unlikely that congenital hypogammaglobulinemia or a complement deficiency would first manifest itself at age 56. Her recently-acquired illness sounds very much like systemic lupus erythematosis. It is not known if lupus alone predisposes to increased risk of infection. Most studies suggest that therapy with steroids leads to infection rather than the underlying disease itself.[3]

The patient's labortory work-up suggests that she had another more likely cause for her overwhelming pneumococcal disease. Howell-Jolly bodies were noted on blood smears; this finding suggests that her spleen was either absent or functioning poorly. The abrupt onset of disease with no perceptible focus of infection, the fulminant course, and her death despite early therapy all are consistent with pneumococcal sepsis in an asplenic host. Moreover, the development of DIC is common in the setting of functional asplenia, but quite unusual in the normal host with pneumococcal bacteremia.[4]

Why is the spleen so important in the defense against pneumococcus? It is likely that susceptibility to pneumococcal infection in asplenic patients is due primarily to the absence of a major phagocytic organ with a large blood flow. When the capacity of the asplenic individual to form specific antibodies is also abnormal, the risk of bacteremia increases further. The spleen plays an important role in the clearance of circulating antigens that are poorly opsonized. Prolonged contact in the sinusoids of the spleen between splenic phagocytes and blood-borne bacteria may allow the phagocytes to recognize material as foreign without the presence of a specific antibody or without activation of complement. Bacteria which are well opsonized with a high concentration of IgG or IgM activate the complement pathway and are sequestered preferentially by the liver. Therefore, the presence of specific antibody may compensate for the lack of functioning splenic tissue by allowing for hepatic sequestration.[5]

The role of the spleen in the production of specific antibodies is less clear. It appears that the spleen may play a role in the shift from the production of IgM specific antibody to IgG antibody production. Present information suggests that because of properidin deficiency in the alternative complement pathway, defective opsonization may also alter host defenses in some asplenic individuals.[6]

Most cases of pneumococcal sepsis in asplenic hosts are the result of splenectomy for trauma, hemolysis, or Hodgkin's disease. It is well recognized that these patients are at increased risk for pneumococcal sepsis as well as for meningococcal, gram negative, and *Hemophilus influenzae* bacteremia.[7] Five patients over four years of age with congenital asplenia or splenic atrophy presenting with pneumococcal sepsis have been reported.[8] These patients ranged in age from 15 to 61 years. Congenital absence of the spleen is rare and often associated with cardiac defects. It is usually detected much earlier in life, but could possibly present at an older age if the patient had been fortunate enough to avoid the offending bacteria. Since our patient did not undergo splenectomy, one must assume that she had another cause for functional asplenia.

Splenic infarction may result in functional asplenia. Sickle cell disease is the best example of this — many small infarcts of the spleen gradually destroy normal tissue with resulting fibrosis. Local thrombosis leading to infarction can occur in polyarteritis nodosa, leukemia, lymphoma, and malaria, all of which seem unlikely except malaria. Emboli from a mural thrombus formed after a myocardial infarction (MI) can cause splenic infarction, but there is no evidence that the patient has had a recent MI. Subacute bacterial endocarditis may also cause infarction of the spleen, but is more often a septic infarct with accumulation of pus, making this diagnosis unlikely in our patient.[9]

Splenic atrophy is the third mechanism that may lead to functional asplenia. Atrophy is quite rare but has been associated with thrombocytopenic purpura, celiac disease, malabsorption, alcoholism, hypopituitarism, hyperthyroidism, ulcerative colitis, and other immune diseases, including systemic lupus erythematosis.[10-12] Our patient had clinical and laboratory evidence of systemic lupus erythematosis, which may have lead to splenic atrophy.

Does the patient's history of living in Africa suggest any other diagnoses? There are a number of illnesses that can affect the spleen, including visceral leishmaniasis or kala-azar, schistosomiasis, and malaria. These result predominantly

in splenomegaly, not present in our patient, and do not cause decreased splenic function with the exception of malaria, which may lead rarely to splenic infarction.

In summary, this 56-year-old missionary nun had Type 25 pneumococcal sepsis with overwhelming infection involving her meninges and serosa. Her predisposing immunological defect appears to have been a lack of opsonization and phagocytosis resulting from functional asplenia. I suspect she did not have cogenital asplenia, but had an atrophic spleen secondary to either chronic malaria or systemic lupus erythematosis.

Pathological Discussion

Enold Dahlquist, Jr., MD: Significant autopsy findings were limited to changes in the spleen, myocardium, kidneys, and lymph nodes. The spleen was normal in weight (150 gm) but showed extensive periarterial fibrosis, focal calcification, hemosiderosis, and irregular capsular thickening, all consistent with functional asplenia. Almost all the pigment was iron. There was also perivascular fibrosis in the myocardium, mild mesangioproliferative glomerulitis, and in the lymph nodes follicular hyperplasia with focal fibrosis and hemosiderosis.

The histolic changes are non-specific, but most likely secondary to chronic, autoimmune hemolytic anemia. These, together with the patient's serologic findings (antinuclear antibody titer as high as 1:640, positive anti-Ro/SSA and anti-La/SSB/He antibodies) and the above-mentioned clinical findings of fever, arthralgia, macular rash, and pancytopenia are, as implied by Doctor Dennehy, strongly supportive of a diagnosis of lupus erythematosus.

While some of the splenic findings were reminiscent of malaria, there was no black pigment and further no malarial parasites were demonstrated.

The cause of death was, therefore, considered to be lupus erythematosus, and the mechansim septicemia with terminal DIC and acute tubular necrosis.

Pathological Diagnosis

Systemic lupus erythematosus with splenic fibrosis and functional asplenia. Terminal septicemia with disseminated intravascular coagulation (DIC) and acute tubular necrosis.

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A New Approach to Medical Malpractice Insurance

Tort System Could Be Bypassed by No-Fault Insurance or a Contractural Arrangement

Jeffrey O'Connell, LLB

It is important to make clear in a group like this one that not only am I a lawyer, I am very proud to be one. Yet I will be the first to admit that we lawyers have made a mess of medical malpractice liability insurance. It should be emphasized, however, that physicians as well as the insurance companies which underwrite liability policies have exacerbated the problem by passively allowing lawyers to establish rules for the payment of persons injured in the course of medical care.

Basic Deficiencies

There are four basic deficiencies in the medical malpractice liability system that are unique to tort liability insurance. First, the fault of the health care provider must be demonstrated, often in the face of conflicting evidence and testimony. Given the complexity of the human body and the range of possible error when procedures are performed or medicines prescribed, it is extremely difficult to prove that the health care provider was at fault. In no other form of insurance are these kinds of decisions involved. When a person dies, as an example, the life insurance company does not inquire as to whether he smoked too much or drank too much. The only germane question is whether he is dead.

Second, unlike other insured events, the amount of the award is greatly influenced by subjective judgments. Regardless of the circumstances of death, life insurance policies are worth the face amount of the policy. When a house burns down, the insurance company does not pay more if the house has been in the family for three generations and has a sentimental value for the owners. If the concept of "pain and suffering" were applied to life insurance, a widow could obtain a larger settlement by maintaining that her husband's death was especially grievous for her. In contrast, under the tort liability system, the value of both the economic and non-economic losses of a medical injury are determined in the emotional atmosphere of a courtroom.

Third, despite the fact that future medical expenses may be unknown given the continuing nature of the injury, most awards are granted in lump sums. Except for events which have occurred only once, like a fire or death, most forms of insurance, such as medical, workers' compensation, or disability coverage, cover expenses as they accrue.

Finally, in most jurisdictions, including Rhode Island, the plaintiff is not required to deduct payments from such collateral sources as health insurance, workers' compensation insurance, and sick pay, and may collect more than once for the same injury.

19th Century Origins

In many ways the malpractice liability situation is comparable to the accidents leading to worker injuries that resulted from the "dark satanic mills" that characterized the 19th century. While

Based on a presentation to the Rhode Island Medical Society House of Delegates, September 12, 1985.

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the benefits of the Industrial Revolution are unquestionable, it is undeniable that the modernization of industry extracted a savage toll of injury. Recognizing the absurdity of the litigation system for handling industrial accidents, Bismarck — hardly the most liberal thinker in the course of recent Western civilization — implemented the first "no fault" approach to insurance by establishing a workers' compensation system. Unless the worker deliberately attempted to injure himself, he will receive reimbursement for economic losses. While the system is hardly perfect, few would recommend a return to litigating each accident based on fault.

A similar approach is now being applied to automobile accidents. The second great wave of accidents that began to engulf us after employment injuries (along with railroad accidents) were automobile mishaps. There were two automobiles in St. Louis in 1900, and they collided, leading to the great enrichment of the legal profession. It was axiomatic in the 19th century that every lawyer paid his overhead with one good railroad case each year. But the revenue from railway mishaps was minuscule in comparison to the riches to be earned from automobile accidents. Perhaps 85 per cent of the civil jury docket in many jurisdictions is taken up with automobile accident cases.

Bismarck's solution has been applied to auto accidents in several states, including New York, New Jersey, Connecticut, and Massachusetts. Under the no-fault insurance system, injured parties are reimbursed for their economic losses regardless of the cause of the accident. Financial figures from the New York experience show that substantial savings can result from implementing a "no-fault" approach. In New York every motorist is required to carry at least $10,000 worth of tort liability insurance covering his own negligence. All motorists, however, must also carry $50,000 worth of no-fault insurance payable to themselves and occupants of their own cars for medical expenses and wage losses. Because the legislature was unwilling to dismantle the tort liability system altogether, it was left intact in case of death or substantial impairment. The premium figures, however, reveal that the cost of tort liability insurance is more than twice that of no-fault coverage. In 1983, the average premium for tort liability coverage was $118 compared to $46 for $50,000 worth of no-fault insurance.

No-Fault and Medical Liability

While the no-fault approach is most appropriate for industrial or automobile accidents where a clearly definable mishap has occurred, it also can be extended to many other liability cases. The Medical Offer and Recovery Act, introduced by Representatives Henson Moore (R, Louisiana) and Richard Gephardt (D, Missouri), would encourage a health care provider to offer a settlement within six months of the occurrence of an alleged incident. The settlement is to cover payment for such "net economic losses" as out-of-pocket expenses, including the costs of medical care, lost wages, rehabilitation expenses, and reasonable legal fees. Once the offer had been made, the patient would forfeit all rights to judicial review except possibly to dispute the amount of economic loss as it accrues. There would be no provision for punitive damages or awards for "pain and suffering."

If no settlement offer is made, the case would be adjudicated under the current tort system. The patient would have full access to the courts and could seek noneconomic damages in addition to an award for economic losses. While an earlier version of the bill transferred the burden of proof to the defendant, the current proposal leaves it with the plaintiff.

The bill gives individual states the option of passing such a law. But in those states which had not acted by January 1, 1988, the federal bill would apply to patient care paid for by the federal government. These patients include Medicare beneficiaries, Medicaid recipients, military dependents, veterans, and federal employees.

Unlike previous attempts to modify the tort system in a piecemeal fashion, this bill seeks to remove the concept of tort liability from the process. It faces considerable opposition both in Congress and in state legislatures from trial lawyers with a vested interest in tort liability. The tort system has an inherent logic to it, especially during the 19th century when almost all tort actions were torts of intentional injuries. Before the Industrial Revolution, the only way one person could normally hurt another was to attack him with a pole, ax, or fist. Now, however, most actions that lead to tort cases are no longer heinous, intentional acts, but rather errors or omissions of the sort we all can make. They are the inevitable result of a technology which created the possibility of costly error by persons who were acting inadvertently, whether driving a car, operating a punch press, or performing surgery. Admittedly, though, it remains difficult to overturn the moral

premise that a wronged party should be reimbursed for his "pain and suffering." While state legislatures grudgingly accepted a no-fault approach to workers' compensation and automobile insurance, they may be especially reluctant to apply it to medical liability since physicians are not perceived to be a suffering minority.

Contractual Arrangments

Another potential solution has already proven effective as a means of handling catastrophic sports-related injuries in high school athletic programs.

Essentially bypassing the tort system altogether, the system establishes a contractural arrangement between the school district and the insurance company under which the injured student becomes the "third-party beneficiary." The contract stipulates that if the student is catastrophically injured, the insurance company will guarantee to the school that it will tender a settlement offer covering medical and rehabilitation expenses and lost wages if the student forfeits his right to sue. This system already has been used successfully about twenty times in the past two years for catastrophic athletic injuries. A similar approach may well be usable in medical liability cases without a legislative dismantling of the tort system.

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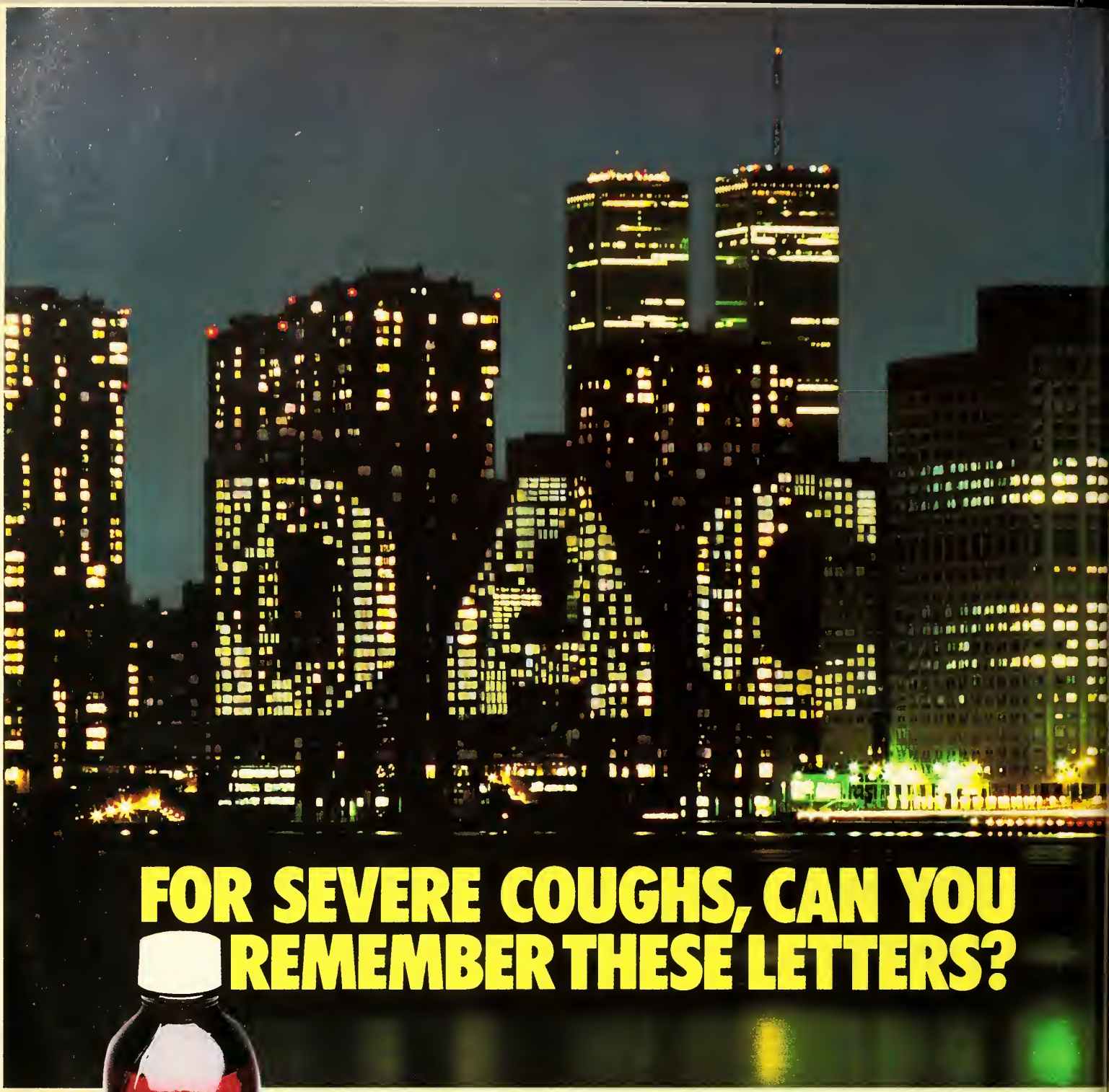
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BOOK REVIEW

Caring for the Terminally Ill

Home Care for the Dying. By Deborah Whiting Little, New York, Doubleday, $9.95, 1985.

It is noteworthy when a medical how-to book is found to be both practical and loving, realistic yet touching. Such is the case with *Home Care for the Dying* by Deborah Whiting Little. Based on the author's experience in caring for her grandmother, who died of cancer in 1978, this eminently practical book gives valuable insights into the difficulties and joys of caring for terminally-ill patients at home.

Its themes are clear. First, every dying person has the right to die at home. Second, the patient is entitled to complete continued relief from all symptoms, whether due to the disease or its treatment. Third, treatment of symptoms is a necessary even elegant endeavor and represents neither simplistic handholding (although this too is needed) nor inappropriate application of medical therapy.

Little states clearly that such treatment represents careful devoted attention on the part of dedicated professionals and caregivers to the needs of dying patients in their final days. The goal of such care is to return to the patient as much control over his life as possible and to assist family and friends in adjusting to this awesome reality.

The author further urges us to examine palliative home care as a realistic option for families of dying patients. She notes that home care offers a unique opportunity to surround the patient with tangible evidence of his or her continued value and to focus attention on what still may be accomplished during the remainder of the patient's life. The book also addresses the awareness of the fears experienced by both patients and family, of unrelieved suffering, of suffering alone, and of the uncertainty of medical support in the final days of illness.

A competent and caring professional team must be available to provide essential medical services. Few professional caregivers have had



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experience caring for terminally-ill patients at home or understand the concepts of palliative care. Physicians especially may be asked to function in the home setting and to render opinions concerning diagnosis and length of life without the benefit of complete diagnostic testing. They may also be asked to ratify "no code" decisions as well as provide narcotic relief of symptoms in doses not usually utilized in office practice. Families must seek a physician willing to make house calls and attend to the patient's symptoms. The professional staff, though possibly unfamiliar with this work, must be completely committed to the patient's comfort. Nurses, homemakers, home health aides, and other personnel must be available to assist in the patient's care.

The stresses experienced by each segment of the care team are described in detail and useful advice given to help caregivers anticipate, recognize, and deal with crisis. For example, home care may cause serious physical and emotional damage to the person responsible for care unless a determined effort is made to prevent burnout. The author emphasizes repeatedly that the caregiver is more at risk than the patient for such burnout, based in part on such assumptions as that the patient's care cannot continue much longer and that no one else can provide care as well.

Caregivers must be allowed to feel that they have contributed in a worthwhile way and that their efforts really made a difference. As patients approach death, they may distance themselves and begin to disconnect themselves from persons and activities they love. Caregivers see this and may feel hurt by this distancing, but they must be helped to let go, to resist the temptation to call patients back, or to resent their separation. A careful process of purposeful detachment and setting of appropriate limits may permit caregivers a smoother transition following the patient's death.

Other chapters discuss such issues as the impact of care and illness on the household and family, how visitors and friends may be affected, the hard practical choices of whether final care will best be accomplished in the hospital or at home, the terminal illness of a child, and the necessary grieving process that must occur to maintain the health of the caregiver following the patient's death.

Much has been written about the use of narcotics in the final stages of terminal illness, and discussions regarding euthanasia and its relevance to home care for the dying are frequent. In es-

sence, the point is emphasized that the patient has the right to live as well as possible until the time of death, in the place chosen by the patient and agreed to by the family. Whether suffering from severe pain or other untoward symptoms, the patient has the right, and we in the medical profession have the opportunity, to provide singular and effective relief with compassion.

Little, as well as several other authors during the past few years, has succeeded in demonstrating that home care for the dying is a realistic alternative. Through her own experience and research, and through her own grief, she has enabled us to see beauty in the midst of tragedy. She urges us to offer to those for whom we care the chance to die at home if that is their wish. Representing the most honored ideals in medical practice, home care for the dying patient offers those who accept it a final opportunity to acknowledge what their life has meant at a time when technology can no longer prevent death from occurring. This book is a welcome addition to the growing literature describing the needs of terminally-ill patients and their families and is highly recommended for all who devote themselves to easing the burden of impending death in the last days of life.

Bruno Borenstein, MD

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The Hewlett-Packard Company has announced a new, fully integrated quantification software package for the HP 77020 AC/AR phased-array Doppler imaging systems. This software allows a physician or sonographer to obtain real-time Doppler measurements and calculations during a patient's visit and retain them for playback. The need for the patient to return for additional scanning can be reduced as can the time spent making manual calculations at the end of the day. Moreover, real-time data can provide surgeons with the quantitative, decision-making information they need to determine whether further testing is required.

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A controlled study from the University of Arkansas College of Medicine in Little Rock suggests that human subjects can control their immune response to some viral challenges. Tested in a three-part study was the response of a person practiced in meditation to skin exposure to varicella zoster. "The data confirmed that this subject could voluntarily modulate her immune response by a psychic mechanism," say Dr. Richard G. Smith and his colleagues in the November 1985 issue of the *Archives of Internal Medicine*. "It appears that the subject, acting with intention, was able to affect not only her skin test response but also the response of her lymphocyte studies in the laboratory."

• • •

A study from the Mayo Clinic in Rochester, Minnesota suggests that the incidence of Guillain-Barre syndrome cannot be associated with swine flu (A/New Jersey/76) vaccinations. A 46-year study of Olmstead County residents uncovered 48 cases of the syndrome, report Doctor Ettore Behi and his colleagues in the November 1985 issue of the *Archives of Neurology*. "No trend over time was evident in the 46-year period, nor did any significant seasonal distribution of cases appear," according to the researchers. Emphasizing a US Army study that failed to find an increase in the syndrome despite widespread use of the 1976 vaccine, they point out that their review results correspond to other studies that question any association of the neurologic syndrome with flu vaccines and to ongoing surveillance programs.

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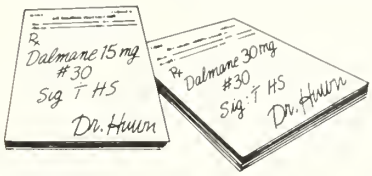
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Newsletter

RHODE ISLAND MEDICAL SOCIETY
March 1986

Herbert Rakatansky, MD, President
Wendy J. Smith, Editor

MEDICAL LIABILITY COALITION CALLS FOR STRONGER DISCIPLINARY BOARD

The failure or inability to share information among state and federal agencies responsible for monitoring medical care has "seriously handicapped" disciplinary activities in Rhode Island, representatives from the Rhode Island Medical Liability Coalition told the General Assembly's medical malpractice commission late last month.

To "strengthen physician review and disciplinary procedures," the coalition supported merger of the state Board of Medical Review and the medical licensing division of the Rhode Island Department of Health into one Board of Licensure and Discipline under the health department. The restructured board, the coalition recommended, should be autonomous in ruling on professional and disciplinary measures.

In other actions concerning the new board, the coalition:

- emphasized that the board should be responsible for investigating malpractice claims against physicians and hospitals
- recommended appointment of a physician as full-time medical director
- recommended that the board be empowered to "monitor the medical staff credentialing" process of hospitals
- called for the reporting of disciplinary actions by the board to all licensed health care facilities
- said that the board should be empowered to suspend a medical license immediately when there is apparent imminent danger to the public

MALPRACTICE (continued)

The coalition also endorsed the concepts of linking medical malpractice premiums to merit, limiting attorneys' contingency fees, and restricting the amount of awards for such intangible claims as pain and suffering.

The coalition also called for:

- pre-judgment interest rates computed at eight per cent instead of the current 12 per cent and from the date of the lawsuit instead of the date of the alleged injury
- restriction on the statute of limitation from three to two years
- a cap of $250,000 on awards for pain and suffering
- a limitation on wrongful death actions to two years from the date of the alleged malpractice or death, whichever occurred first. In no case may a wrongful death action be filed more than four years after death.
- limitations on attorneys' contingency fees to 40 per cent of the first $50,000, 33-1/3 per cent of the next $50,000, 25 per cent of the next $100,000, and 10 per cent of all awards greater than $200,000
- regular inspections by the Department of Health of all licensed health care facilities to "maintain high professional standards and good patient care"
- stronger credentialing policies by Rhode Island hospitals

The Rhode Island Medical Liability Coali-

tion consists of 17 organizations which met under the aegis of the Hospital Association of Rhode Island (HARI) throughout the fall and winter. Included in the coalition were representatives from the Rhode Island Medical Society, HARI, Rhode Island Business Group on Health, Federation of Rhode Island Chambers of Commerce, the Joint Underwriting Association, Ocean State Physicians' Health Plan, Starkweather and Shepley Insurance Agency, Rhode Island State Nurses Association, and the Rhode Island Society of Hospital Risk Managers. To aid in its deliberations, the coalition received testimony from physicians, hospitals, insurance companies, the JUA, attorneys, and representatives from the Department of Business Regulation and the Governor's Office.

300 DOCTORS MASS AT MALPRACTICE RALLY

More than 300 Rhode Island physicians rallied February 5 to express their viewpoints on the malpractice crisis. Nearly 300 persons squeezed into the Rhode Island Department of Health auditorium, leaving another 150 milling about in the corridors. The hearing was eventually moved to the Veterans Memorial Auditorium.

Among those who testified before the Legislative Commission on Medical Malpractice was Doctor Charles P. Shoemaker, Jr., past RIMS president, who pointed out that the malpractice crisis has interfered with hiring much-needed personnel at Newport Hospital.

Referring to assertions by the Rhode Island Trial Lawyers Association that physicians must strengthen their disciplinary procedures before seeking limits on malpractice suits, Shoemaker pointed out that the Society is "very concerned" about policing its members. Even if incompetent doctors were weeded out of the profession, he said, malpractice suits would continue because "there will always be unfortunate results."

Doctor David P. Carter, president of the Rhode Island chapter of the American Academy of Family Physicians, told the commission that he already has eliminated obstetrics from his practice and is considering no longer assisting at surgery. He also noted that the crisis has created problems in his search for a partner. Doctor Clinton B. Potter, a Providence obstetrician/gynecologist, said that he also is eliminating obstetrics because the threat of a lawsuit makes it "no longer possible to do good obstetrics. And we refuse to practice mediocre medicine to satisfy the requirements of the legal profession."

The February 5 open hearing was part of a series of meetings the commission has held with physicians, attorneys, the Joint Underwriting Association, the Board of Medical Review, hospitals, legal expert Jeffrey O'Connell from the University of Virginia, and consumer advocate Ralph Nader. The 18-member commission, which is expected to issue majority and minority reports later this spring, includes eight attorneys, six of whom are plaintiff's attorneys; one judge; three physicians; one insurance claims manager; one hospital association executive; one housewife; one retardation center executive; and two college professors. It was appointed by the General Assembly in 1984 in lieu of acting on a five-part malpractice reform package introduced by the Rhode Island Medical Society.

JUA FACES $100 MILLION DEFICIT

The Medical Malpractice Joint Underwriting Association of Rhode Island showed a $100 million deficit as of December 31, 1985, according to a report recently issued by the Rhode Island Medical Liability Coalition.

The average payment rose from $20,000 in 1979 to $79,000 in 1984. There was a 960 per cent increase in the number of settlements from 1980 (15 cases) to 1984 (145 cases). Moreover, it was reported by an actuary last spring that the JUA lost money seven out of nine years during the period 1975-1983. It was further noted

JUA (continued)

that claims applicable to the earlier years, ie, 1975 and 1976, are still being filed eleven years later.

If the JUA depletes its cash reserves and stabilization reserve fund, the report points out, all casualty insurance carriers in the state will become liable for the deficit which they may make up by increasing the premiums for all policyholders.

These findings were released as part of the Rhode Island Medical Liability Coalition's report to the Legislative Commission on Medical Malpractice.

SOCIETY ENDORSES MERGER

The Rhode Island Medical Society recently endorsed a plan by Governor Edward D. DiPrete to merge the Board of Medical Review, the disciplinary agency for the state's physicians, and the licensure division of the Rhode Island Department of Health. The Board currently functions as an autonomous agency reporting directly to the General Assembly. The restructured board would function under the aegis of the health department.

In a letter to the governor, Doctor Herbert Rakatansky, RIMS President, cited the Society's support for "strong peer review to improve the quality of medical care delivered to the citizens of Rhode Island."

He further stated, "We also believe that it is critical that the Medical Society have input into evaluating the qualifications of physicians appointed to the Board of Medical Review. This would insure that only physicians of high ability and ethical and moral character are put in this very special position of public trust."

The RIMS Council approved the merger at its February 3 meeting. In other actions, the Council also:

- received a report from Doctor Paul J.M. Healey, one of three physicians on the Legislative Commission on Medical Malpractice

COUNCIL (continued)

- appointed the following physicians to the Long-Range Planning Committee: Doctors David P. Carter, Peter D.T. Clarisse, Robert P. Davis, Elaine B. Fain, Seebert J. Goldowsky, Milton W. Hamolsky, Paul J.M. Healey, Herbert Rakatansky, and Charles P. Shoemaker, Jr.

- received a report from the Public Laws Committee. While malpractice reform legislation remains of primary interest, it was noted that several other health-related bills have been introduced, including those related to mandatory Medicare reimbursement, seat belts, smoking, and physician reimbursement.

- reviewed the unaudited financial statement for the year ended December 31, 1985.

PERINATAL CONFERENCE TO BE HELD IN SPRING

The Ninth Annual Seminar on Current Concepts in Prenatal and Neonatal Care will feature plenary sessions and workshops on low birth weight infants, intraventricular hemorrhage, cultural aspects of childbearing, perinatal aspects of AIDS, cardiac arrythmias, and low alpha fetoprotein. Speakers at the two-day meeting, to be held May 29-30 at the Sheraton Islander in Newport, include Doctors Edmund A. Egan, State University of New York at Buffalo; Robert L. Goldenberg, University of Alabama; Laura R. Ment, Yale University School of Medicine; and Irwin R. Merkatz, Albert Einstein College of Medicine; and local speakers.

Sponsored by the Rhode Island Medical Society, the meeting is organized by the Society's Perinatal Committee under the direction of Doctors William Oh and Lorand Brown. Co-sponsors include the RI Chapter, American Academy of Pediatrics; RI Section, American College of Obstetricians/Gynecologists; RI Section, Nurses Section, ACOG; Brown University; Women & Infants' Hospital; and the Rhode Island Department of Health.

For further information and registration forms, please call or write the Society's offices at 106 Francis Street, Providence 02903 (401/331-3207).

PRACTICE MANAGEMENT QUESTION OF THE MONTH:

HOW TO PREPARE A PROFESSIONAL CURRICULUM VITAE

A curriculum vitae can serve a variety of functions and may be especially valuable when you are:

Applying for a professional position: While this is the most obvious function of a CV, it should be emphasized that the content and format of your CV reflect the degree of your professionalism. A CV is a valuable time saver. When applying for several positions, for example, it is necesaary only to write a brief cover letter that expresses your interest in the opening and that describes your strengths and career aspirations.

Giving a speech: A CV can also provide a useful summary for the purpose of an introduction when you are giving a speech. An up-to-date CV obviously saves a great deal of time and may eliminate the need to complete special applications or summary forms. Its comprehensiveness means that the organization can select what it needs from the extensive materials you have provided.

Being presented with an award or inducted into an honor society: Your CV will also become indispensable if you are a candidate for an award or a medical organization appointment.

Submitting a paper, article, or book idea to a publisher: If you ever submit a paper, an article, or a book idea to a publisher, the reaction will be based somewhat on your CV. If you have the required educational and professional experience or if you have published previously in the subject area, the publisher may have more confidence in the integrity of your proposal.

What to include:

Brevity and simplicity are the keys to an effective CV. Many CVs fail because they provide too much information, rather than not enough, especially in recruitment situations. Your CV should be as brief and as tightly written as possible. While acceptable length varies with the age and experience of the applicant, one to two pages is the general rule. If you need more space, some experts recommend developing two CVs, a brief one that describes the essential elements of your training, experience, and capabilities, and a longer version that elaborates on these elements and includes a bibliography.

The recommended elements of a CV include your name, address, and telephone number (home and office/hospital), licensing information, education, practice and other professional experience, and professorial or teaching appointments. You might also include any awards and honors, professional society memberships and offices held, personal data, and a bibliography. Your CV should account for all the time since completion of college. The information does not have to be detailed, but it should be apparent that you have been engaged in productive, career-related activities throughout the years. Your CV should not be cluttered with part-time jobs, however, unless they are directly related to your profession.

When to update:

Your CV should be completely updated when something in your career changes, ie, when you move or obtain a new position, publish additional books or papers, or complete additional postgraduate work. These entries should not be made in handwriting.

Rhode Island Medical Journal

March 1986
Volume 69, Number 3

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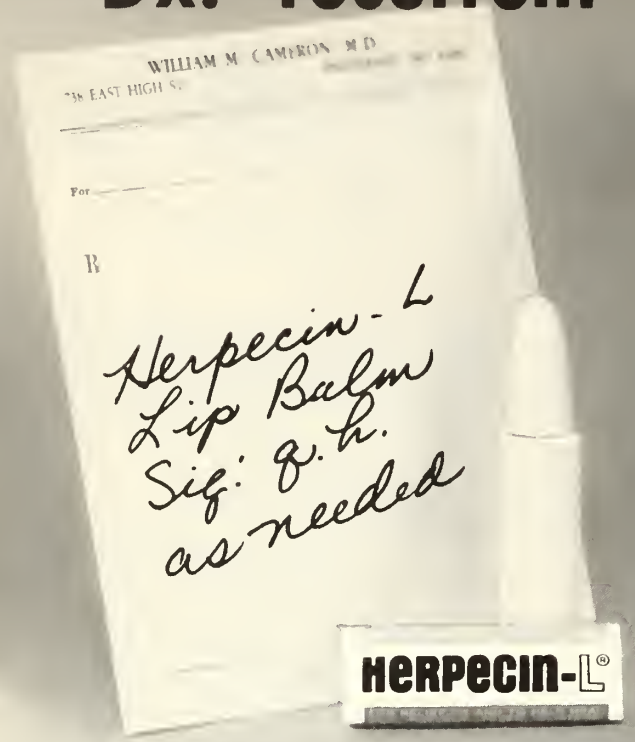
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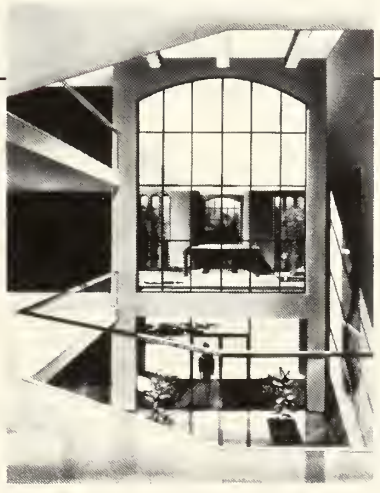
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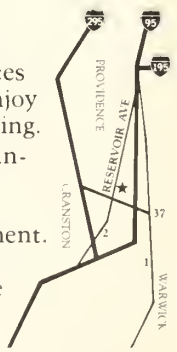
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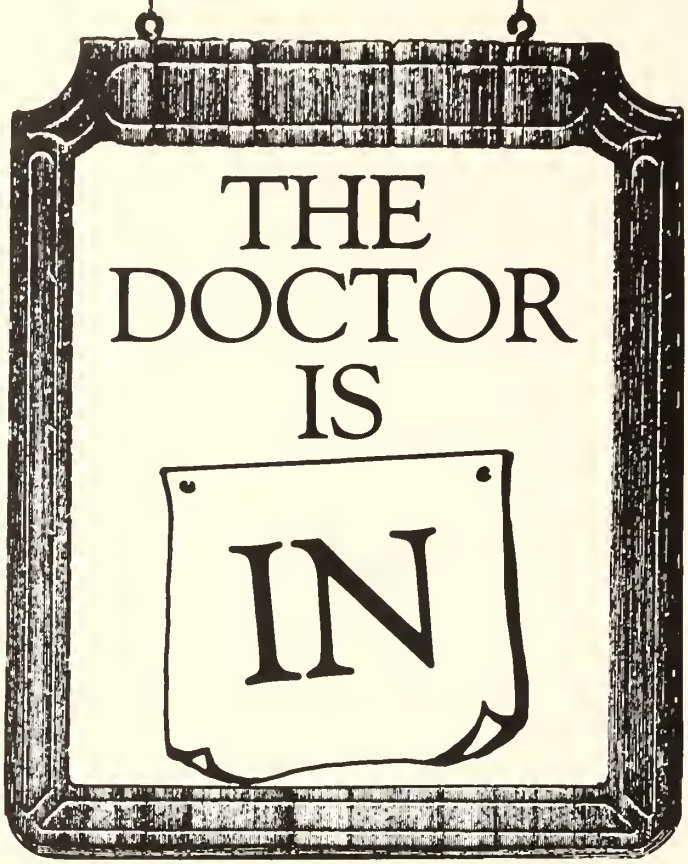
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Helping hands: Sister Beverly Furtado, a Catholic chaplain at Rhode Island Hospital, comforts a patient. See page 103. Photograph courtesy of Rhode Island Hospital.



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EDITORIAL

Religion and Medicine

Today's hospitals provide medical care for the very ill, activities which are largely designed and furnished by physicians; but there was a time when hospitals were places solely of retreat and shelter, run by religious orders for the benefit of the disabled and dying. Indeed, to this day, many of our hospitals are still managed by religious denominations seeking the common ground of secular and spiritual purpose. Clearly, both professionals, medicine and clergy, are in the business of caring for distressed persons. Just as today's intensive care unit physician is substantially removed from the barber-surgeon of the fourteenth century, so too is today's hospital chaplain a marked departure from his medieval predecessor.

This issue of the *Rhode Island Medical Journal* examines the current role of religion in the care of the sick individual, offering four essays which explore the hospital chaplaincy program in Rhode Island, the role of the clergy in addressing ethical dilemmas in medicine, the clergy in homes for the aged, and finally inquiry as to whether religion may participate in the education of the physician.

Interfaith Healthcare Ministries, Rhode Island's clinical pastoral education facility, was begun in 1974 as an enterprise for reconciling the differing perceptions of illness held by the hospital physician and the hospital chaplain, as well as for the purpose of establishing an accredited educational program for the training of future hospital chaplains. Interfaith has now trained many hundreds of individual pastors of various faiths for service in hospitals, nursing homes, and other settings where they may bring to patients, " . . . an awareness of personal worth and dignity . . . and to enable those in the crisis of illness to discover their personal and spiritual strengths." These chaplains in training, coming from parishes in the United States, Europe, Africa, and Asia, undertook more than 30,000 hospital patient visits in the greater Providence area during 1985. Physicians from the Brown University Program in Medicine, as well as from the practicing community, have participated actively in the classroom training of these chaplains. Interfaith clergy representing all faiths have taught Brown medical students and house staff in the ethical dimensions of human disease. The paper written by Sister Dorothy Cotterell and the Reverend William Nisi examines the background and purposes of Interfaith Health Care Ministries and its activities in the eight hospitals of the Brown University medical school consortium.

The Reverend David Ames, Episcopal Chaplain to Brown University and the Rhode Island School of Design, is a member of the Research and Human Rights Committee as well as the Bioethics Committee at Women & Infants' Hospital and is active in the Human Values and Ethics Program in the Brown University medical school. His paper explores yet another dimension of chaplaincy purpose, namely, as a provider of spiritual perspective in addressing the ever-increasing numbers of ethical dilemmas of clinical medicine.

We are reminded that the nursing homes of Rhode Island give shelter to three times as many disabled individuals as do the state's hospitals and here too the ministering chaplaincy has an important role to fulfill. Rabbis Gutterman and Silverman talk sensitively of the many problems addressed by visiting clergy in the nursing homes and the homes for the elderly.

The Reverend Daniel Burke, who was for many years chaplain to the University of Michigan Medical School, talks of the role of clergy as ". . . interpreter or reminder of things like aspiration, fear, obligation, guilt, commitment, and alienation as well as the celebrated trilogy of faith, hope, and love are ever lurking on the scene with every bit as much power to sicken or heal as any trauma, micro-organism, or neoplasm, any blade, laser, or cytotoxin." He deplores the liturgy which states, "We have the word, you listen," and suggests, alternatively, as do all the essayists, that "we listen."

The words in these essays are worth listening to. The editors of the *Journal* would welcome letters from the readers expressing their views on the contents of this issue.

Stanley M. Aronson, MD

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PRESIDENT'S PAGE

Confidentiality of Medical Records: Good News and Bad News

Two recent decisions by the Rhode Island Supreme Court provide us with both good and bad news regarding medical records.

First the bad news. In 1972 a Robert Bartlett was riding a motorcycle and collided with a car driven by one William Danti. Mr. Danti had a history of a previous head injury and resultant partial disability. Bartlett requested the medical records of Danti. These records were protected by Rhode Island statute regarding confidentiality of medical records, which stated that such records could not be produced without the patient's permission. The Supreme Court decided, however, that this section of the law was unconstitutional. Thus, individual medical records are now subject to subpoena if they are pertinent to litigation.

This is bad policy. Traditionally, the doctor is bound to a code of silence concerning what he or she learns during the relationship with the patient. This tradition is thousands of years old, having started with Hippocrates. It is so ingrained in our medical practice that it is not questioned by either the doctor or the patient. The patient fully expects complete confidentiality, and successful treatment often hinges on information divulged with that expectation. Traditionally the lawyer-client relationship and the priest-parishioner relationship have been considered sacrosanct along with the doctor-patient relationship. Now the demands of "justice" have eroded that once solid and impregnable heritage. I submit that the doctor-patient confidentiality has at least as long as, if not a longer, history than that of the lawyer or priest. It is at least as vital to the welfare of the individual as the others. If "justice" demands the breach of medical confidentiality, then the other privileged communications should be breached also. Why is one more or less important than another?



Herbert Rakatansky, MD

I suspect that very few, if any, patients realize what has happened. They continue to assume that whatever they tell the physician is confidential. The problem is particularly acute for psychiatrists, who, if they are not to risk revelation of their patient's intimate disclosures, must have a prodigious, if not photographic, memory. RIMS will work with its attorneys to find a remedy for this unfortunate situation.

Now for the good news. In April 1978, Charles

Cofone was admitted to Westerly Hospital with a postoperative infection. Two years later he sued the hospital and requested that the records of the infection control committee be made available. The infection control committee is a peer review committee under Rhode Island law. As such, its records are protected from discovery and they may not be used in evidence in a trial except in the case of litigation arising out of sanctions imposed on a physician. However, in 1983 the trial judge ruled that the hospital must produce the records. The hospital appealed this decision to the Rhode Island Supreme Court. The Rhode Island Medical Society filed a brief with the court supporting the Westerly Hospital position. On January 25, 1986, attorney Mark Mandell filed a brief stating that he represented many persons who would be affected and requested that the case be reopened for further argument. The court rendered a ruling on February 6, 1986 ruling that the records were protected under the law and could not be discovered. The court also denied attorney Mandell's request to reopen the case.

Successful peer review depends on frank and open discussion by peers. If the records of such discussions were available to the patients, it is doubtful that there would be any significant peer review at all. Unfortunately, this fact of life is not appreciated by everyone. The Rhode Island legislature, however, realized this when the law was passed, and the Supreme Court has now upheld this doctrine.

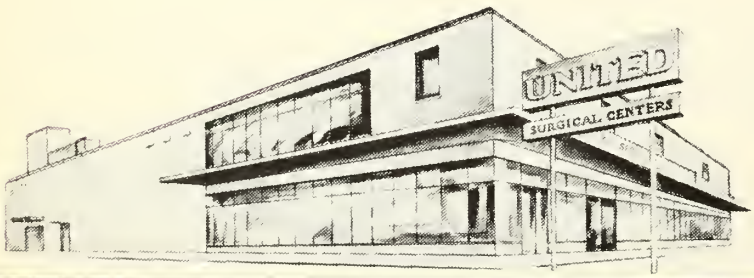
The Rhode Island Medical Society is in favor of strong peer review. Accountability to the public is appropriate when sanctions are taken against a doctor. In fact, the law requires a report to the Board of Medical Review whenever a hospital reduces a doctor's privileges for clinical reasons. The Board is responsive to the public, and all of its final decisions are public. The interactive process of constant education is essential to the practice of medicine. To inhibit it would be detrimental to the patient and the public.

The legislature and the courts realize this, and we applaud their wisdom.

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A Role for Religion in the Education of Physicians?

Role of the Clergy Seen as Interpreter of Emotions Such as Aspiration, Fear, Obligation, Guilt, and Commitment

Daniel Burke, BA, MDiv

My *Webster's Unabridged Dictionary*, the one which can get me into a siege of low back difficulty if I am not careful how I lift and move it, still insists on beginning its definitions by tracing back the language roots of a word. Thus it is that medicine, from the Latin *medicina*, is first described as the healing art before further explanation goes on to speak of it as a "science and art" for diagnosing, treating, curing, and preventing disease; relieving pain; and preserving health.

In this same vein religion is noted as also being from the Latin *religare*, which means to bind back. There is mention, too, of the related noun, *religio*, which has to do with piety, scrupulousness, and conscientiousness.

What role could the activity of binding back humans in the interest of piety, scrupulosity, and conscience have to to with the art and science of healing? It seems to me that the role here is the same as that vis-a-vis the art of governing or politics, the same role as that assumed by religion vis-a-vis any human art, or science for that matter. In its loyalty or devotion to God (piety) and to the singularly human trait of evaluation, religion binds people back from the presumptions of definitiveness.

I realize I have to qualify this and say religion, when it is at its best, does this. The unfortunate fact is that some religionists (like some non-religionists) have absolutized their concerns and conclusions and then compounded the error by trying to imperialize others with their claims. But this should not blind us to the importance of the insight which arose historically from the soil of biblical religion. It is the insight embedded indelibly in the annals of human beings in the legends of those first eleven chapters of Genesis. We are not to make the mistake of regarding ourselves, singularly or in the aggregate, as the measure of all things. In fact, the point is pressed home with an ominous warning. It is a deadly mistake for us so to construe ourselves.

The fact this admonition is observed in the breach more essentially than in the observance does nothing to dispel its accuracy as the all-too-lethal history of the race discloses. No doubt this is why there is such an enterprise as religion. Somewhere, some way, someone has to keep calling our attention to the thought that we are not ourselves and do not possess the definitive word about reality up to and including the definitive word about what is right or wrong in it.

There is a great hue and cry around these days about or against something which is identified as secular humanism. It comes most noticeably from some quarters of religion. Insofar as it represents an effort to remind us that we are not the final arbiters of reality, I can hardly argue with it as my remarks would indicate. Unfortunately, however, it moves beyond the bounds of legitimate criticism and becomes a parody of itself by moving to shut down even open-minded forms of inquiry in the name of God. There are some paradoxes, as I am attempting to point out, that we have to accept; that is not one of them.

The din created by this often misguided zeal ignores or threatens to drown out a more pro-

The Rev. Daniel Burke, BA, MDiv, is Rector of St. Martin's Episcopal Church, Providence, Rhode Island, and has been a frequent guest lecturer at the Brown University Program in Medicine.

found realization. The Bible sets forth its own brand of humanism which is as far-reaching and celebratory of human powers and potential as we could possibly imagine. Beginning in the familiar creation story (Genesis 1:26ff), picked up by the psalmist (Psalm 8:3ff), and repeated in the New Testament in the Letter to the Hebrews (2:8ff) the Bible contends that what we are is of the stuff of God even if not the entirety. What this means is that dominion in respect to the works of creation is given over to us. We are expected, indeed enjoined, to know it, to subdue it, and make it serve our purposes. What is more, this delegation of power is declared to be a very good thing. Knowledge is, as the academic dogma has it, a good thing. It seems hard to imagine a more complete endorsement than this for the human enterprise.

All of which might prompt us to ask — which side of the story is true? The answer is both. What the Bible and biblical religion (at is best) is trying to say, I believe, is that human existence is too complex a matter to be summed up in one clause.

When Jesus was asked what was the great commandment in the law, the one upon which all the rest depended, he gave a very interesting answer. He said there were two and, in fact, the second of the two has two parts. His answer was the stringing together of two ancient Israelite ordinances: (1) ". . . you shall love the Lord your God with all your heart, and with all your soul, and with all your might." (Deuteronomy 6:5); and (2) ". . . you shall love your neighbor as yourself. . ." (Leviticus 19:18). Like human existence itself, the moral life is too complex a matter to be boiled down to one directive. Loving or, we might say, paying attention to God has only a most limited, or perhaps even no meaning as a thing in itself. It finds its meaning or expression in paying attention to or caring for one's neighbor, which in turn is intimately bound up with, of all things, regard for oneself. Biblically speaking, you have not finished the business of dealing with God until you have dealt with the human. And you have not dealt fully with the human side of the story until you affirm the other as surely as you do yourself.

The picture drawn by the biblical narrative of the core of moral life and of all life is one of strange paradoxes or, we might better say, of unyielding complimentarity. On the one hand an interdiction of absolute knowledge, on the other an invitation to pursue all knowledge. A piety which insists its reverence for God cannot be divorced from a like regard for others and self.

What does all this have to do with, or where does this all come down in terms of the clinical situation, or of the laboratory for that matter? These are the payoff questions of medical education, research, and practice, and they are eminently fair ones for medicine to ask of religion. Since there is little, if anything, religion can add to the pools of contemporary biomedical science and technology, the contribution has to be in the matter of approach and in matters of value.

The first application then is the admonition first received — resist all claims on final truth, beginning with your own. On closer inspection even the imperium of God is visible as a big giveaway. Be content with successive approximations and help others to be content with them, too.

Does this sound like too much of a truism? Then why, in matters of life and death from neonatology to thanatology, are we so hung up waiting for a definition of "person" or "human" which is never going to arrive? This does not mean we should never attempt any definitions. It does mean we have to make do with the best we can do and stop holding ourselves, especially the suffering and lost causes among ourselves, hostage to a presumptuous fantasy. It is at least as much in the approach as in any definitions the "answer" is to be found.

Then, too, there are lots of little ways in which each of us, especially when we have paid our dues and are considered expert at something, can regard ourselves as possessing the last word. They may be little ways of presuming too much, but they can and do add up to great damage. The problem with idolatry, which is one of the biblical ways of describing this behavior, is not so much that it offends God as that it distorts us. That distortion of us is more likely what is offensive to God.

Secondly, and this follows from the paradox or complimentarity of life noted above, religion, it seems to me, should be an encouragement to medicine to go for the knowledge its science seeks as well as a reminder that it is also and evermore will be an art. There is a kind of disdain for soft data in contemporary medicine which is or can be injurious not only to the patients but to the profession as well. We may not agree on the use of language such as image of God or children of God when it comes to describing human beings, but what we are dealing with is not mere protoplasm, the gallbladder in the third bed. It is useful to remember that language is used with greatest obscurity and data are often the softest

in areas which are of the greatest importance to us. H. Boone Porter, a clergy colleague of mine, put it this way:

> In the market place, when one wants to be exact about business matters, one resorts to mathematics. In the temple, on the other hand, when one wants to be very exact about spiritual matters, one resorts to parables, ceremony, music, and other arts . . . The language of religion has to do with what is always some extent beyond us, something we are reaching for, grasping for — and also what is reaching and reaching for us from a realm outside ourselves.

About spiritual matters another colleague, William Rankin, said even more succinctly, "To speak of the human spirit, however, requires the use of the language of inference and poetry more than of quantity and measurement."

We of the clergy are accustomed to this use of language and to dealing with soft data. It can be very frustrating in an epoch smitten with the empirical, but the darn stuff just won't go away. Because the problem will not go away, we will be available either as interpreter or reminder that things like aspiration, fear, obligation, guilt, commitment, and alienation as well as the celebrated trilogy of faith, hope, and love are ever lurking on the scene with every bit as much power to sicken or heal us as any trauma, micro-organism, or neoplasm, any blade, laser, or cytotoxin. Physicians must factor these things of the human spirit and the value people attach to them into the regimen lest they betray not only the art of their profession, but also the patients who commit themselves to their care. But in the meantime and by all means let us plunge on with equal parts of diligence and ethical concern in the business of reconnoitering the kingdoms of virus or protein, and unraveling the mysteries of brain biochemistry and the genetic code.

Lastly, and again in the matter of dealing with the neighbor as oneself, it may be that medicine can learn something from the mistakes of religion. Although we lead the ceremonial and propound the poetry and directives which are aimed at disclosing meaning and giving coherence to life, we do not always obey the motions our pronouncements are intended to establish.

There is something indelibly democratic about the biblical exposition of life. Everyone is equidistant before and equally, not to say infinitely, valued by God. By extension this applies also to any age; all are equally arranged and prized, all equally redolent of potential and failure. It ill behooves an age such as ours, for instance, which threatens the world with nuclear obliteration to look or speak with scorn of any dark age of the past. What this means is that our worth or, as Rankin puts it, our dignity is inherent; it is just because we exist, not because of any "good" reasons that we are affirmed and affirmable. God's being no respector of persons is the active norm in history against which all our schemes of priority may be brought to naught. This may not be a very efficient way to run a universe and efficiency has its place, but it is somewhere behind fairness, especially when the tincture which colors everything is mercy.

We should resist the impulse, the temptation to answer for another. Communication means holding in common; responsibility means ability to respond. We hold in common as human beings, whatever our station, the ability to respond for ourselves until and unless it is drummed out of us. Even then it remains as a potential.

The sick and the suffering, I well realize, often want to be relieved of this essential liberty which illness has a way of converting to a burden. No profession is more likely than medicine to receive the proxy implied in the question, "What would you do, doctor?" It is fair enough, in dire circumstances, to move to relieve the burden of others by giving an answer or making response for them. But it is also very dangerous water, full of the shoals of selves groping continually with the problem of control. The decision to allow another, even the expert, to be in charge is more a moment-to-moment than a permanent decision. That is just as it should be and even a sign of health, although it can be terribly difficult to deal with as the dreadful siege of malpratice claims discloses. Sickness may reduce us to dependence, but cure or even coping means moving back, in the best of all worlds, toward a situation of interdependence — ". . . you shall love your neighbor as yourself."

I realize I have restricted religion in this essay to that which is identified as biblical. Even here there are so many strains and nuances that one claims representative status only at great peril. But is is my religious frame of reference and therefore the only one I could possibly speak of with any authenticity.

Though it has been abused by friend and foe alike, its incredible durability suggests that its insights can stand the test of time and repay the effort to find and refine them in every age. Since one of its chief concerns is healing in every dimension of the meaning of the word, it would seem to have some place even if only adjunct or, better, adjuvant to the art and science of medicine.

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Chaplaincy in Today's Hospitals

Interfaith Health Care Ministries Is Dedicated to Providing Chaplaincy Services to Patients in Brown-Affiliated Hospitals

Dorothy Cotterell, MDiv
William F. Nisi, ThM

Suddenly it seemed quiet in the hospital room. J. looked around, but his eyes kept coming back to the wires connected to his chest. "How many hours ago was it," he thought, "that the chest pains came?" That awful moment when he knew something was wrong, but hoped it would go away. It did not. He thought about how frightened his wife was. He wished she were here, but she had to go back and take care of their two boys. It was like a blur, like watching himself on TV — the ride in the ambulance, the people who rushed at him in the emergency room. "God, am I going to die, why me?" he thought. He remembered the doctor when he finally said, "We're going to admit your for tests. Don't worry. Try to relax." He remembered his wife's worried face. "How could this happen," he thought, "I'm only 44."

"Hello, J., may I come in?" The voice broke through his thoughts. "Sure," he replied. "I'm S.J., a chaplain here at the hospital." They shook hands as the chaplain pulled up a chair and sat down. "How are you doing," the chaplain asked. "Okay," J. replied. "It must have been frightening for you," the chaplain said. Tears surfaced as J. tried to respond. The chaplain touched his hand, and J. began to talk about his feelings and fears, began telling his story of the previous hours.

For those of us who work in hospitals, this is a familiar scene. For those of us who face trauma every day, it is difficult to keep close to the anxiety and the fear that accompany the crisis of illness. The threat of the unknown, the loss of a familiar environment, the absence of relationships, the feeling of isolation when one is frightened and fears saying it out loud.

J. felt scared, but he thought he needed to reassure his family that he was all right, and above all that he was maintaining control of himself. Yet the more he told himself to relax, the more anxious he became. It was into this highly personal and emotionally charged setting that the chaplain came. The task for the chaplain and the relationship offered to J. was unique. The chaplain was not in a hurry so he sat down. The primary concern was not the physical treatment, but helping the patient verbalize the facts and the feelings of the last several hours. The chaplain sat, listened, offered support, but no pat answers. Through this support and encouragement, the chaplain conveyed acceptance — acceptance of J.'s feelings and concerns. As J. talked, he began to feel better as he realized that it was all right to feel as he did. More important, as he shared his thoughts and feelings they seemed not so threatening. In fact, he began to feel calmer. J. experienced a moment of caring.

J. was in the hospital for two weeks. Tests were carried out and information shared. There was a blockage to be treated, and J. had to think of changing his life style, a new diet, and exercise. During this time J. talked often with the chaplain. Initially he expressed his anger at God for doing this to him and his anger at himself for smoking and overeating. He discussed his underlying fear that this would happen again and his concern that he might die before his children were raised. As time went on, J. was able to forgive himself

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The Rev. William F. Nisi, ThM, is Director of Pastoral Care, Interfaith Health Care Ministries, Providence, Rhode Island.

and plan for a new future. He was able to discover God as a positive resource for his life rather than a distant critical judge. J. discovered in his illness a new perspective of himself and discovered inner resources that would be a source of strength to him as he moved into a different future. The day that J. left the hospital, he said to the chaplain, "Thank you. Your caring for me through all of this has helped me more than you will ever know."

In this encounter the chaplain came as a concerned listener, as a presence to help the patient sort through the feelings and emotions associated with his trauma. The patient's spirit was healed as he made peace with himself and found resources to cope with the future.

In the highly technical milieu of the modern hospital with all of its resources for cure, the chaplain is one whose main function is to provide care. While pastoral care involves listening, supporting, helping, and healing, it is more than each of these words alone. It is entering into the world of those who are ill and forming a relationship with them, a relationship which is determined to stay with them even when nothing can be done to cure them. In the highly technical setting of the modern hospital, the chaplain facilitates the powerful resources of pastoral care and of the religious community with its ritual and tradition, to bring dignity, quality, and direction to the lives of the patients.

Describing chaplaincy and pastoral care is difficult because it deals with the personal and spiritual part of life and as such involves words and metaphors that are foreign to the scientific world. Moreover, chaplaincy is still often viewed from the traditional mode, ie, sacramental ministry, evangelization, and providing someone to cheer up the ill. For those persons, chaplaincy is seen as a frill or an ancillary service when, indeed, today's chaplain, male or female, is a trained professional and an integral part of the health care team.

Fortunately, many of the old conceptual barriers between religion and health care are beginning to crumble. There is perhaps some irony in the fact that the economic crisis in health care delivery has challenged health care providers to seek new paradigms for envisioning its task:

> The new paradigms emphasize health (vis-a-vis pathology), systems (vis-a-vis specialties), disease as process (vis-a-vis disease as entity), patient as autonomous (vis-a-vis patient as dependent), professional as therapeutic partner (vis-a-vis professional as authority) and body-mind-spirit as a unit (vis-a-vis body-mind-spirit as a treated entity.)[1]

These new ways of envisioning the health care task emphasize the person as a whole being — physical, emotional, spiritual. Thus, treating the patient as a whole being involves and invites collaboration between all the disciplines that seek to provide care and sometimes cure. Ideally, the professional chaplain is equipped to do more, especially with the emotional and spiritual, thus facilitating an integration of care and when possible, cure.

While the health care team may at times have difficulty envisioning the role of the chaplain and the role of religion in health care, it is also true that religion has had difficulty in asserting its uniqueness in a way that is understood and respected by the scientific world. Yet, as the barriers tend to crumble between health care and religion, there are some limited strides being made in research. While more needs to be done, some studies indicate that pastoral care facilitates healing.[2-4] Research will continue to focus on the healing process and the interface between religion and health.

The Training of the Chaplain

As in other health care disciplines, chaplaincy in the modern hospital requires professional training. Interfaith Health Care Ministries (IHCM) in Providence, Rhode Island is one of 350 accredited centers offering clinical pastoral education (CPE) to men and women of the clergy and qualified lay persons.[5]

Interfaith was founded ten years ago through the initiation and cooperation of the Brown University Program in Medicine and seven affiliated hospitals: Emma Pendleton Bradley Hospital, Butler Hospital, Memorial Hospital, The Miriam Hospital, Roger Williams General Hospital, Rhode Island Hospital, and Women & Infants' Hospital; the Diocese of Providence, the Rhode Island State Council of Churches, and the Board of Rabbis. The program was founded to provide professionally trained chaplains in the Brown affiliated programs and to enhance the quality of pastoral care throughout the community. More than 230 persons have received training at Interfaith during the past ten years, and most of the chaplains in Rhode Island institutions have received their education at Interfaith. IHCM is known both nationally and internationally for its educational excellence.

Interfaith is accredited by the Association for Clinical Pastoral Education (ACPE) and the National Association of Catholic Chaplains (NACC) to provide clinical pastoral education. Clinical

pastoral education is an action/reflection model of education. The thrust of CPE is to expose students to persons in crisis (patients) and from the experience of providing pastoral care (learning by doing), to help the students understand the dynamics in themselves and in patients and in the relationship between themselves and patients. The student's experiences are brought to the scrutiny of their supervisors and peers for examination and reflection. As students learn to listen more perceptively and empathically, they also learn to help patients articulate their dilemmas more openly and in turn help them to discover inner resources that will help them to cope with their problems. Although the primary focus of their learning is on providing pastoral care to patients, a parallel to the patient focus is to increase the students' awareness of themselves both as persons and as ministers. This dimension of CPE, while demanding and challenging, enhances both professional growth and quality ministry, and minimizes the possibility that the chaplain interns will inflict their needs and values on patients. CPE is an intense and often exhausting method of professional training but, because effective chaplaincy is so personal and so demanding, it must be so.

In Providence, Rhode Island, the amount of services provided by students is more than one might expect from an educational endeavor. For example, during a period from January 1 to July 31, 1985, student chaplains recorded 15,418 visits. An ongoing question for supervisors concerns the quality of pastoral care provided by our chaplains. While we have no hard research data on the question, we do have experience, observation, and feedback, namely, that the inner spirit of the patient is cared for and moved toward healing when there has been pastoral ministry from a well-qualified chaplain.

Pastoral Care and the Future

Current national issues and trends in health care challenge the role and function of the hospital chaplain and in turn impact on the curriculum for CPE training. High technology is creating complex ethical problems for physicians, health care professionals, patients, and families. Increasingly, help in arriving at humane and just decisions is being sought from religious resources. As a representative of the faith community, training of persons for hospital ministry must include this important dimension. In addition to being involved in the informed decision-making process, the chaplain must be available to help persons live with the results of decisions that have been made.

Still another trend is the movement of health care from the hospital to the community. Procedures that once required hospitalization are now being done on an outpatient basis. Acute care beds are used for shorter stays. There are increasing numbers of patients too well to be hospitalized, but not well enough to resume their normal activities. The training of chaplains today must include a community focus intent on helping religious groups discover a new partnership with physicians and hospitals in providing support and spiritual care for the isolated and the homebound. As hospital stays decrease, long-term beds are needed for persons with chronic and complicated problems, such as the elderly. Equipping chaplains to work with patients and staff in specialized long-term treatment centers requires a unique sensitivity to the problems of the human spirit. Again, the trained chaplain may be in a position to explore new partnerships with the local health care teams and the religious affiliated group.

The most difficult challenge, however, is the competition for the health care dollar and the reduction of reimbursement for services. How will this affect the chaplaincy in the hospital setting is difficult to determine. Yet there are hopeful signs. Recently the Hospital Corporation of America, with more than 450 hospitals, hired at the corporate level a chaplain to plan for pastoral care and the establishment of Clinical Pastoral Education Centers in its institutions. The early study documents indicate that pastoral care and education are seen as an essential part of health care and an important aspect of health care for the future. This same study underscores the fact that quality health care includes pastoral care offered by trained and certified professionals, and that health care must seek ways by utilizing the resources of the religious community to improve the quality of life. In addition, it reveals a need to establish relationships with religious groups for after-care programs. The future may bring new alliances between religion and the health care industry to offer services in a more comprehensive way.

Summary

In the highly complex modern health care system with the ever-increasing need for specialization and trained professionals, the skilled hospital chaplain brings to patients an awareness of per-

sonal worth and dignity, and seeks to enable those in the crisis of illness to rediscover their personal and spiritual strengths and uncover new ways of experiencing life and its meaning.

The chaplain as a member of the health care team needs training and education in the human sciences, in the art of developing relationships, and in the integration of knowledge with faith. Interfaith Health Care Ministries is a program dedicated to providing chaplaincy education and chaplaincy services to the patients in the hospitals affiliated with the Brown University Program in Medicine.

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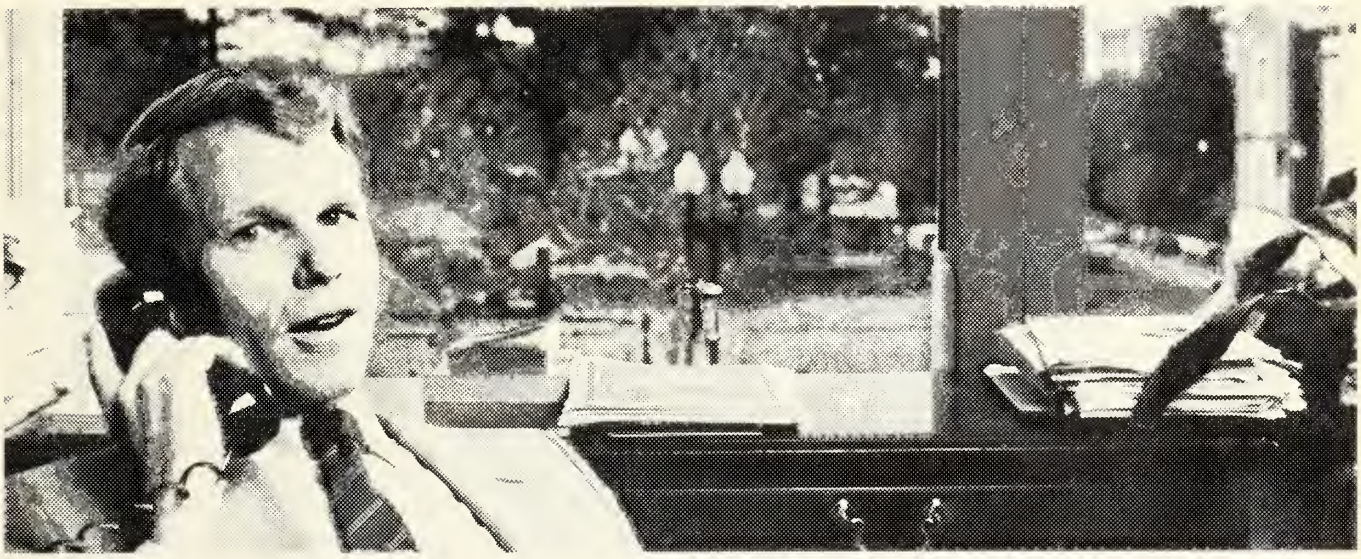
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Ethical Dilemmas in Clinical Medicine

Although Ethical Principles Are Normative Statements and Theoretical Constructs Can Be Applied to Many Situations, Each Case Is Unique

David A. Ames, DMin

It is often said that the practice of medicine is as much an art as it is a science. Ascertaining an accurate diagnosis and applying the appropriate therapeutic remedy is primarily a scientific process. However, in responding to the person with a particular set of symptoms, and in the relationship (however brief or intense) between patient and physician, medical care is an art. The patient's and the physician's values may be compatible and pose virtually no conflict; or they may be diverse and bring about disagreement about what, if anything, ought to be done with respect to the patient's symptoms.

The dilemmas in clinical medicine arise out of our convictions about the values of health and disease, the knowledge and experience we share about diagnoses and treatments, the importance of research and development of new technologies for treatment, and the meaning of life itself. Ordinarily, in discussions of ethical dilemmas, we approach this value dimension of health care through reflective questions and articulated principles. For example, what constitutes informed, or valid consent to treatment, or refusal to accept treatment? When is paternalism justified with respect to withholding information from a patient, or breaching patient confidentiality, or refusing a particular therapy? What guidelines or criteria do we employ for determining "do not resuscitate" orders, or withholding life support, or withdrawing life support? What about the allocation of resources, the criteria and responsibility for determining who receives what benefits and who bears what burdens? These questions do not always have answers that elicit a broad-based consensus. They are value questions, and in any group where there is a diversity of values there will be a variety of convictions, opinions, and attitudes about the direction to follow or the "answer" to be given.

Principles are normative statements which have been articulated and employed through the centuries by physicians, philosophers, and theologians to govern medical care and research. They include several concepts: *beneficence* — to do good, *non-malevolence* — to do no harm; *equality* — to treat everyone alike; *justice* — to allocate resources, costs, and benefits fairly; *veracity* — to inform patients truthfully about their condition and prognosis; *respect* and *autonomy* — to promote individual integrity, dignity, responsibility, rights, and well-being; *mutual trust* — to promote a caring and cooperative relationship between providers and recipients; and *thankfulness* — to be grateful for one's own life and to have gratitude for the lives of others. These principles are derived from several classical theories and include the following: Deontological — rules serve as the basis for determining what is right and wrong; Utilitarian — the good (or love or pleasure) is to be maximized; and Relativistic — societal views, cultural norms, and emotions determine morality. The ethical dilemmas arise when one of these principles comes into conflict with another or others, or when a person or group cannot agree upon a course of action, or when one or more of them is disregarded out of self-interest.

The Rev. David A. Ames, DMin, is Episcopal Chaplain at Brown University and Rhode Island School of Design and has played a major role, both at the Brown University Program in Medicine and in various hospitals, serving on biomedical ethics committees.

Clinical Situations

No discussion of ethics is complete if it is only abstract or theoretical. Ethics is concerned with making decisions in the context of a given situation. What alternatives are present? Which of them ought we to choose? Why choose B instead of A or C? Would a combination of alternatives be better than one alone? Why or why not? How are we to decide?

With respect to health and disease, ethical decision-making involves both the art and science of medicine. It is concerned with the patient, including the patient's life situation, his or her family and social relationships, and his or her function in society. It is also concerned with scientific fact and information as the diagnosis, possible therapeutic modalities, and prognosis affect the best interests of the patient and the patient's own decisions about which course of action or non-action to choose.

The following three situations or case studies provide a clinical dimension to this discussion:

Case A: A primary care resident physician has been treating a 55-year-old married woman, Mrs. K, for two years. When the resident first began caring for Mrs. K, she had a history of alcoholism and stomach problems, but otherwise was in good health. However, Mrs. K's husband, a retired factory worker, had suffered from lung cancer and within the past year was told he had brain metastases. He is an outpatient, but has had several admissions within the past year.

Approximately seven months ago, the resident physician discovered a lump in Mrs. K's breast and the patient underwent a modified radical mastectomy. Over the past two months she has had several admissions to the hospital, most recently for pneumonia. A computed tomographic scan during the current admission has also revealed brain metastases. In addition, analysis of fluid in her lungs indicates a further malignant tumor. It is believed that Mrs. K has less than six months to live.

At the present time, Mrs. K has lost much weight and all of her hair and is frail. She is often incontinent because of side-effects from medication, and she is undergoing chemotherapy. Her mental status indicates some memory impairment, although the resident reports that she has always been a little eccentric and tangential. It is unclear how much she understands about her disease. At one point she telephoned her husband and said tearfully a doctor told her that she was going to die. The following day she said she knew she was sick, but was going to beat this thing; she wanted to go home. Despite his condition, Mr. K appears to be thinking clearly and told the resident, "You have to know that if things get bad, I want her to come home."

Mrs. K, her husband, and two grown sons live in low-income housing. The patient's mother-in-law lives in the same housing complex and has been available to care for her and her husband. A visiting nurse is also involved with the family.

The resident is concerned because the oncology team wants Mrs. K to remain in the hospital to undergo a new chemotherapy regimen. If successful, this treatment could extend her life by several months. It would require a longer hospital stay and some additional risk, including greater possibility for infection.

The hospital social worker has expressed concern about discharging Mrs. K to her home because she has reason to believe one of the sons is selling the patient's pain medication on the street.

Case B: Timothy R. was born at a community hospital on March 12, three weeks before his due date and weighing 2.85 kg. His mother was 35 years old and had had two previous pregnancies. The infant needed to be intubated at birth for profound muscle weakness throughout his entire body and was thus transferred to the neonatology unit at a university hospital.

The baby's hospital course over the first two months of life has been marked by continued profound muscle weakness necessitating respirator support. Timothy was extubated for a three-week period from April 2 to April 23, after which he has remained respirator-dependent. It is likely that Timothy will require continued respirator therapy for an indefinite period.

Timothy has been seen by a variety of medical consultants, including neonatologists, neurologists, ophthalmologists, geneticists, cardiologists, and neuropathologists. To date these individuals and the various tests they have ordered have been unable to provide a definitive diagnosis. It appears, however, that Timothy has a primary muscle disease, although his central nervous system appears to be affected as well. A CT scan was abnormal, showing: (1) calcifications suggestive of possible intrauterine infection; and (2) ventricular dilatation. The patient does not appear to have purposeful eye movement; rather, they are roving and disconjugate although the patient does respond to suctioning of the endotracheal tube and withdraws to painful stimuli.

The mother's history is significant for psychiatric illness. The nature of this is not well-defined although she has been treated with lithium and was hospitalized about twelve years ago for this reason. Although she has not been evaluated by a psychiatrist in the recent past, the mother is felt to be competent by her family practitioner. She is currently being followed by a mental health therapist at a community mental health center. Mrs. R has given her two previous children up for adoption. One is a ten-year-old who lives with an aunt in the same city. This is Mrs. R's second marriage. Timothy is the first child of this marriage and the first child of the baby's father. The parents have been extremely devoted to Timothy, visiting him for several hours each day. Although they seem to be realistic about his progress, the parents want Timothy weaned from the respirator and discharged so they can care for him at home.

Case C: A relatively new therapy in reproductive technology has been introduced at Women & Infants' Hospital. This therapy is *in vitro* fertilization (IVF) and it offers a new measure of hope (the success rate for IVF is about 20 per cent) to infertile couples attempting to conceive a child.

Under the guidance of Doctor Ray Haning, Jr., Director of the Division of Reproductive Endocrinology, the hospital has developed a carefully formulated program and protocol for IVF therapy. Information prepared for interested and qualified couples includes: (a) a brochure outlining the program; (b) a letter responding to an initial inquiry; (c) a sheet explaining what is required at the initial visit; (d) requirements for acceptance into the IVF program; (e) a "case study" of a sample cycle of *in vitro* fertilization; (f) a three-page informed consent outlining required steps, problems, and risks of the procedure, the success rate, and a place for the couple to indicate the number of eggs (from one to seven) they desire to have inseminated; (g) an information document of 6 single-spaced pages on monitoring the woman's cycle, egg retrieval, fertilization process, embryo transfer, predictable chances for pregnancy, and risk of abnormalities, monitoring gestational growth, publicity, and costs ($150 for the initial visit, $5,000 estimated per cycle); and (h) a protocol for *in vitro* fertilization, transfer, and implementation.

For acceptance into the IVF program, requirements are that "one or more of the following conditions are present: (a) absence or blockage of both fallopian tubes that is deemed uncorrectable by current surgical methods or likely to yield low success rates, (b) extensive pelvic adhesive disease with ovaries that are observable via laparoscopy, (c) endometriosis that has failed to respond to appropriate therapy, (d) compromised semen quality, or (e) infertility of undetermined etiology wherein the staff of the institution have reviewed all of the couple's past records and deem *in vitro* fertilization as a reasonable means of attaining pregnancy." Additionally, the husband must have semen quality that will yield reasonable expectation of success with *in vitro* fertilization; the wife must have a normal uterus and at least one ovary accessible for egg retrieval; she should "ordinarily" be under 41 years of age; married couples only will be accepted; and the estimated cost must be prepaid.

It should be pointed out that insurance companies do not as yet provide coverage for this therapy. Further, if the husband's sperm is not suitable for IVF because of a low count or poor motility, donor semen (commonly used in artificial insemination) is not being used in this program at this time. Of the eggs obtained by laparoscopy, the most immature are discarded without insemination and those eggs which are inseminated (up to seven) are examined after a period of 16 hours to count the number of pronuclei. Those failing to demonstate two pronuclei, required for normal fertilization, are discarded after they show signs of disintegration and cell death. All eggs demonstrating normal fertilization and cell division are to be transferred into the patient's uterus within 72 hours of insemination.

A further point to be made is that no experimentation is to be conducted on any egg which has been inseminated, regardless of its demonstrated fertilization and development.

Several questions arise for discussion about each of these situations. It is important always to have a complete understanding of the medical facts, diagnosis, treatment modalities, and prognosis, and also the relevant personal data concerning patient needs and ability to participate in decisions affecting their well-being. A complete discussion of these case situations for the purpose of this paper is secondary to the articulation of the ethical questions and issues which they evoke.

With respect to case situation A, there are at least the following questions: (1) How direct should the physician be in telling Mrs. K the truth about her illness? (2) What role should the resident take in the decision about continued hospitalization for the new chemotherapy? (3) How important are the concerns raised by the social worker concerning discharge planning? (4) What course of therapy/care would you recommend given the available information and how do you justify your decision?

Case situation B suggests at least three concerns: (1) the ethical and legal implications of sending Timothy home on a respirator, possibly following the insertion of a tracheostomy tube are: (a) the family concern about their vulnerability to accusations of "murder" should he die at home; and (b) the hospital staff concern about the family's long-term emotional and financial capability if Timothy is discharged; (2) At some future time, in three to six months, for example, could Timothy be removed from the respirator and a decision be made not to reintubate him? (3) Are the parents really concerned about doing what is in Timothy's best interests, or do they anticipate his possible death if their desire for a discharge is granted? Is this unstated concern a factor in granting their request?

Case situation C presents a different set of ethical concerns. These concerns focus more on social policy and the direction IVF therapy points toward in further developments in reproductive technology. The $5,000 cost is not covered by insurance. Should third-party payers provide coverage for this therapy? At what level? What do we have to say about the level of priority for IVF in relation to other kinds of medical therapy and health care? With a success rate of 20 per cent, which does not take into consideration the statistical possibility of miscarriage, do the benefits of IVF outweigh the risks? If the husband has unsuitable semen for *in vitro* fertilization, what reasons are there for both for and against using donor sperm, either fresh or frozen? Should we be troubled by the problems of failure that plague other than new IVF clinics around the country? Presently, there are no regulations or controls for IVF therapy programs in the United States. Are they needed and how should they be developed? The Australian state of Victoria has passed the Infertility (Medical Procedures) Act in order to regulate IVF. The protocol in use at Women & Infants' Hospital is very much in line with the Australian practice. But, do we not also need to examine other possible developments, including frozen embryos and surrogate parenting?

Conclusion

In each of these case situations, one could develop a clear set of reasons for choosing more than one response. For example, in Case A, an argument could be made for keeping Mrs. K in the hospital for the new chemotherapy treatment. It would benefit her because her life may be prolonged by as much as two months. The value of life itself is the crucial issue for making this judgment. Or, one could argue with equal validity that the relationship between Mrs. K and Mr. K is paramount; it would be more important for them to have time together than for Mrs. K to have the possibility of two more months of

life. The same kind of reasoning can be applied to Case B. Timothy belongs at home with his parents because they bear the primary responsibility for his care and nurturing, and their wishes are to be respected. Or, one could argue with equal cogency that it would not be in Timothy's best interest to remove him from the respirator at this time. More tests need to be done, a longer period of observation and study is required because his diagnosis is unclear. It would be too much of a risk to discharge him.

Although ethical principles, or moral rules, function as normative statements, and theoretical constructs and arguments can be applied to any number of situations, each case is unique. It is important to know why we might respond in Case A in one way and perhaps to Case B in another. The relationship between physician and patient and the patient's family is crucial. Its very quality may determine the outcome of an ethical dilemma.

Most teaching hospitals and medical schools now have an interdisciplinary forum, case conferences, or grand rounds to bring out all the myriad possible alternatives, value conflicts, opinions, and attitudes we would have. The goals of such gatherings are not so much to seek consensus as to analyze how we might respond to each situation and the values or principles upon which we justify that response.

Finally, at the level of social policy, the introduction of an IVF program, or for that matter almost any new technology, raises a number of concerns which need discussion and debate as the technology is implemented and developed. Policy and guidelines will evolve and the best interests of society, including individuals and communities, will be served as a result of thorough local and state consideration of the issues along with the work of national committees and professional conferences.

Acknowledgment

The author wishes to acknowledge the contributions of case material for this paper by Ray V. Haning, Jr., MD; Carol Landau, PhD; and John A. Widness, MD.

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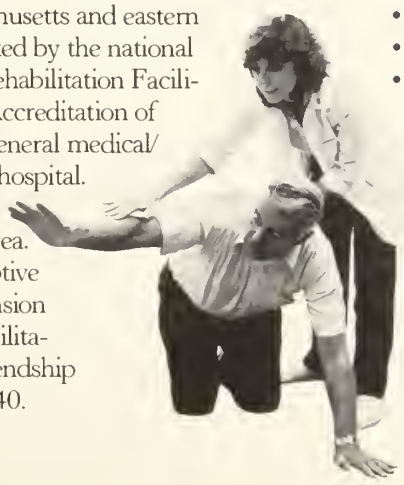


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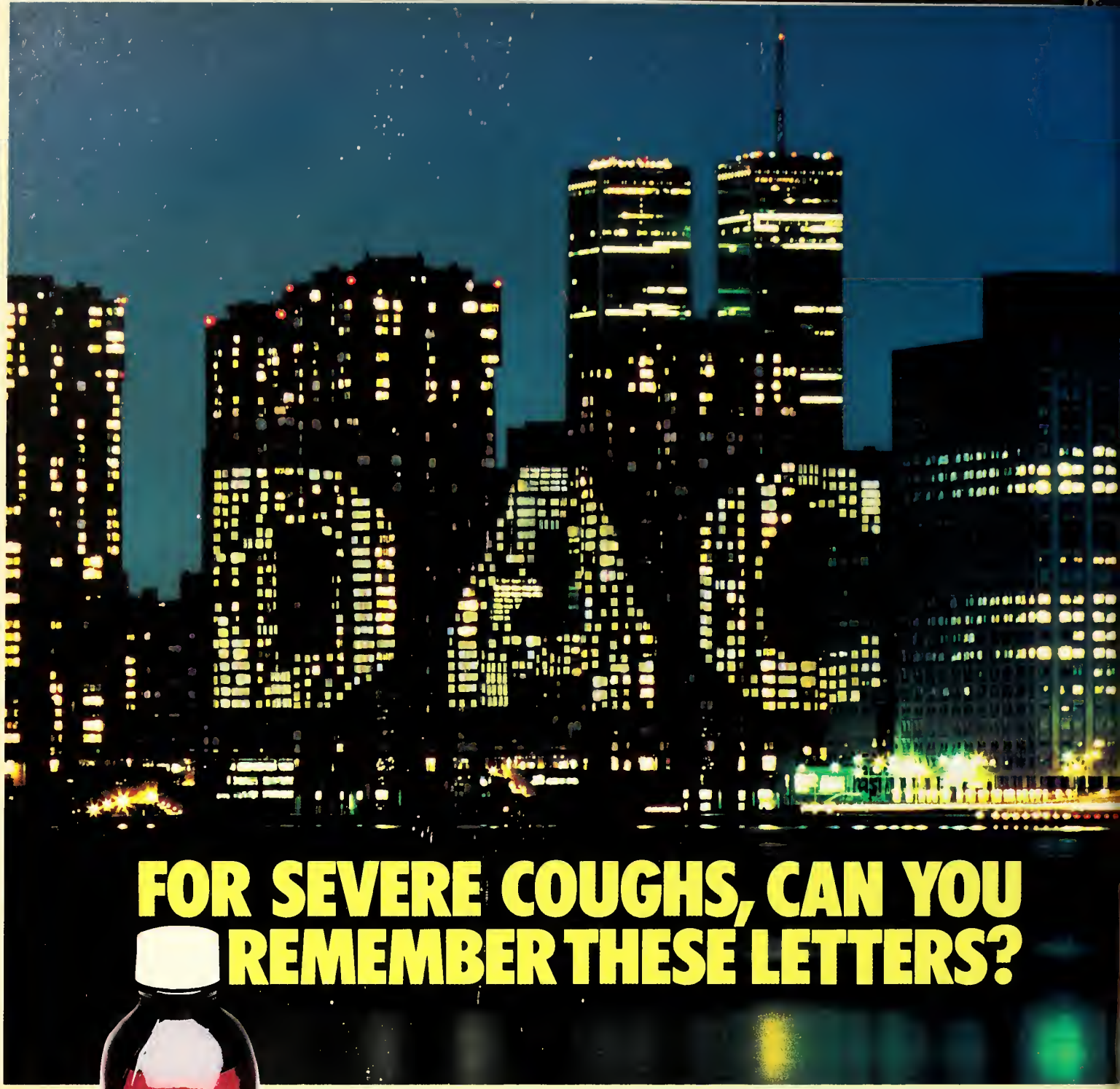


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Chaplaincy in Homes for the Aged

This Special Chaplaincy Is a Process of Offering the Gifts of Empathy and Understanding

Leslie Y. Gutterman, BA, MAHL
Lawrence M. Silverman, MA, DHL

It is difficult to characterize old age, but it is a time when most must accept new, disruptive changes. These men and women are now retired and have had to accept new change involved in giving up the work-role, the way in which many had defined themselves. The elderly are no longer part of the "mainstream." Then, too, there are the new changes which a loss of physical capability entails. Visual and hearing impairments, lessened mobility, declining physical endurance are all part of the picture. Such dimunition estranges people from their environment and from others. Old age has been defined as a period of coping with losses in role, status, income, and health. No wonder that the answer to the riddle, "What is it that everybody wants to become, but nobody wants to be?" is "old." Old age is often bewildering and traumatic. Thus the Psalmist's plea, "Cast me not off in the time of old age; when my strength faileth, forsake me not."

Many of our mothers and fathers are spending these years in institutional geriatric settings which offer special challenges and opportunities to the chaplain. "What we owe the old is reverence," exclaimed Abraham Joshua Herschel, "but all they ask for is consideration, attention, not to be discarded and forgotten." Often that is the chaplain's stock in trade, consideration and attention. Chaplains spend time. Chaplains sit with a person without rushing off. They can convey to another human being that they are still people of worth just by being with them for no other purpose than listening to their story.

As one chaplain told us, "I establish meaning for the residents of my home by allowing them to rehearse their tales. I allow them to give me love which is nurturing and life-sustaining for them even as it is for me." Elderly people need to be loved and to love. They need to be touched, not to be hurried. A chaplain does not view himself or herself as a busy staff person. His function is to offer a sense of unhurried presence.

One chaplain tells of reading Russell Baker's memoir *Growing Up* to a 94-year-old resident in a local nursing home and witnessing the woman laugh out loud with exuberance at the word "gumption." I haven't heard that word for so many years," she whispered with delight as a new light appeared in her eyes.

Chaplains tell such stories as they affirm the personality of another by spending time. Often it is to hear the story of an ultimate in sorrow, the tragic circumstance of a parent losing a child. King David's lament, "My son Absalom . . . would I have died instead of you, Absalom my son" can be heard in many a nursing home if one will only stop a few moments to listen. A chaplain is often the only one able to help a person in a home for the aged work through past unresolved grief as well as dealing with seeing friends die daily. Chaplains encounter residents as people. They engage them as fellow human beings and often challenge them to interact with the man or woman in the adjoining chair or bed. The chaplain's presence becomes a catalyst for their relating to one another.

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Chaplains in these restrictive environments recognize that it is a family that goes through the transition of aging. Many invaluable services are rendered by supporting these family groups as they deal with the ambivalent feelings that are inevitably part of the decision to place a loved on in a health-care facility. Primarily, however, this special chaplaincy is a process of offering the gift of self, the gifts of empathy and understanding.

Abandonment is, perhaps, the greatest fear of the old person and the greatest cause of his or her despair. This is the case even for the fortunate few who find residence in those special facilities which provide for a regular visitation by a chaplain. For what happens to many people when they are beset by old age? What happens at this critical period in their lives? All too often the old person's family says, "Who will take care of him?" They say, "What she needs most at her age is to be comfortable." They dare to say, "He's lived his life, we only want that he should not suffer." Further, when they tell this older person that they have found "the right kind" of place for him or her to live in, he or she will often agree that this move is probably for the best. The old person will often state that he or she does not want to be a burden on the family, and that it would be good to be in a situation where the people are trained to provide exactly the kind of care needed.

But when that individual goes to this new home, a degree of depression often sets in. On the one hand, the family together with the support system of the institution (possibly including a chaplain) can point to the regular meals, the round-the-clock nursing, the possibility of companionship, and more-or-less appropriate programming. On the other hand, the old person is affected by an overwhelming sense of uprootedness, loss of privacy, and a feeling of humiliation because of being reduced to a state of total dependence. The tragic irony is that, while the move to the home may really be appropriate, the feelings resulting are real and often inescapable.

When one first moves, for the first weeks and maybe even months, often all one can think about is the question, "When am I going *home*?" "How long do I have to stay here," the person asks, and is told, "until you can manage better on your own" or "don't ask until you give it a chance. Wait and see." For many of the elderly who go through this phase of depression, a change begins to take place. He or she begins to protest, perhaps only as a way of holding on to his sanity, to maintain that at least he can still think and therefore live independently. Often, however, this period of protest is discounted by others as mere complaining, which indeed some of it may be.

When members of the family visit, the older relative may want to know why they do not visit more often, or why they never take him out for a ride or home for dinner or home for the weekend. If the members of the family already feel a measure of guilt about the fact that their parent/grandparent is in a home for the aged, this kind of conversation will only reinforce their guilt and have the unfortunate result of driving some members away. At this point, intervention by the chaplain is critical and may be very helpful. The chaplain may become the best channel for the individual and his family to resume communicating effectively. The chaplain, too, may be of great benefit to the family in helping them cope with their guilt and their feelings of inadequacy about being able to take care of their older relative. The chaplain may also become the older person's "safety valve," the one who is sincerely interested to hear all the complaints, who will know which are genuine and call for action, but who will not take the complaining so personally as to be driven away.

Among the aged, there is a proverb which says that, in old age, one's character is the same as in younger years, "only more so." Some people are unrealistic in terms of their expectations and, perhaps, are unaccepting of their present condition because they have always tended to avoid reality. Some individuals, on the other hand, may always have been such realists, that in old age they seem melancholic. One problem often noted by chaplains is that younger relatives of one type sometimes have to deal with an older person of the other type. This tragic kind of generation gap may be set into relief through the following account:

A ninety-six-year-old woman was diagnosed as having an inoperable cancer. Up to this time she had never been a complainer but, on the contrary, was an active participant in the life of the home in which she lived. But when the time came for her to be hospitalized, her family intervened with the physician and appealed to him not to tell their mother the reason for her hospitalization. The family based their request upon their conviction that their mother would hear the medical diagnosis as a "death verdict" and would lose all desire to live. The physician agreed, and for

a time the family visited their mother frequently in the hospital, deflected questions about when she would be going home, and, as they said afterwords, basically carried on small talk.

During one of these visits, the family met the chaplain and said that they wanted to discuss a problem. They were finding it difficult to carry on any meaningful conversation with their relative, they said, and their visits were becoming more difficult for them to bear. In short, they were inclined to visit less often. At the time, the chaplain merely encouraged them to continue their visits. The chaplain noted, however, that the family's secrecy about their relative's disease was probably more for their imagined benefit than for hers.

When the chaplain next visited the woman, he heard the other side of the situation from her. She claimed that her family had become withdrawn and that "they only talk about the same old stuff." The woman said: "They won't even tell me why they're keeping me here. Do you know why? Do you know what's wrong with me?" The chaplain's relationship with this woman was such that he determined instantly to answer her directly and honestly. When he had finished this explanation, briefly and calmly, the woman replied, "Well, it's about time someone had the decency to tell me what's going on with my life. It's my life, you know. I'm not a little girl anymore. I can take it." Moreover, she was right. She already had suspected the worst, but she felt humiliated by the fact that her family assiduously avoided this subject with her. As for the chaplain, he was subsequently taken to task, albeit briefly, by the director of the home from which the woman came. But the family later reported that communications with their hospitalized relative were back to normal and, indeed, they had never been better. There was much crying the next time they met, but also from then on the desire to share with each other what was most important in their lives.

Intervention by the chaplain, as the previous account illustrates, may entail certain risks. Yet, the chaplain's commitment is to try to see all the individuals involved as whole human beings, not only in terms of the medical crisis that has brought them together. Often physicians, the nursing staff, and the family as well share and support this commitment. But when some other members of the team do not, the chaplain may find that they too can benefit from his counsel, spiritual guidance, or both. For medical professionals, this need may arise from the simple fact that they are, by desire and training, helpers and healers. Yet when their patient is an individual who is suffering from the ravages of old age, they find themselves unable to heal and often feel helpless.

The role of the chaplain may thus include helping staff members to deal with harsh realities that impinge on their own feelings of growing older and out-of-control. The chaplain here can help the staff deal with unresolved grief. He or she can be the person who allows the nurse on the floor, or others who are confronting their own mortality, to have these feelings come more to the surface and to work them through. The chaplain can be the listening ear, when often there is a kind of conspiracy of silence about the effect that working with older people has on health professionals. The chaplain can be attuned to this kind of an agenda and try to develop a sixth sense for knowing when an informal counseling session with another staff member may be appropriate.

Despite the manifold negative factors involved in ministering to the spiritual and physical needs of the aged, the chaplain often finds personal satisfaction simply in the relationship that builds as he or she draws close to another human being. As one of our elders put it, "The death rate for all of us is still one hundred per cent." It is superfluous to acknowledge that this is true. More to the point is the observation that the chaplain, as well as many other professionals in the geriatric field, is in a position to develop the sense that these older human beings are just that: older human beings. All of us walk the same path; only the older person is farther along, almost at the end; but it is still the same path. Moreover, sometimes an older individual, in spite of many of the afflictions of age, manifests such a strong sense of purpose and capacity for renewal as to be literally an inspiration to younger generations.

The story is told of another nonagenarian who survived his period of adjustment at the home for the aged where he lived, so much so that he came to find contentment there. As he had been philosophical throughout his life, so was he in confronting the fact of his old age. He felt keenly that everyday was a step closer to his own death, and at the same time, gave thanks for each day as one more day of life that was his to experience.

This individual choose to spend his days by not giving up on all the great and small things that meant life to him. He was still somewhat skilled in carpentry; he liked to feel close to na-

ture; and in summer as well as winter, he would look for birds to come and eat from the feeder he had made and set in the courtyard outside his room. He was also a painter of modest talent, who loved landscapes; and he painted them in simple watercolors, as he remembered them, as he wanted to see them. For him, the chaplain became a special friend for whom he could display and explain his work, adding that he had many ideas for new works that he was ready to begin.

Readiness to make new beginnings was perhaps the hallmark of this man's contentment. Yet it was a readiness balanced by an unremitting realism about his own human condition. He never felt cheated because some mythical eternal youth of the body could not be his. He knew in his own life what it meant, as Ecclesiastes writes, "when the keepers of the house tremble, and the strong men bow themselves." He knew the nervous disorders, the susceptibility to viruses, the broken hips, and the faulty kidneys that were his lot. He knew that he was gradually going the way of all the earth. Even in his last moment, he struggled against loneliness; and a hand placed in his at the bedside was gripped with a death-grip. In that moment, that was all that bound him still to life. It was life that he loved; and that friend holding his hand, standing out there with his feet in the living world, meant life to him.

For the chaplain, then, there are special blessings attending to this work, as the following verse, called "Beatitudes for Friends of the Aged," suggest:

> Blessed are they who understand my faltering step and unsteady hand,
> Who know that my ears today must strain to catch the things they say . . .
> Blessed are they who looked away
> When coffee spilled at the table today.
> Blessed are they with a cheery smile,
> Who stop to chat for a little while.
> Blessed are they who never say
> You've told that story twice today . . .
> Blessed are they who make it known
> That I'm loved, respected, and not alone.

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Clear-cut advantages for early surgical intervention have been demonstrated by the Diabetic Retinopathy Vitrectomy Study, a multicenter, randomized clinical trial supported by the National Eye Insitute. In the study, 1,600 eyes reduced to visual acuity of 5/200 or less were randomly assigned to either early surgical intervention or intervention delayed for one year. After two years, 25 per cent of the early group had visual acuity of 10/20 or better compared with 15 per cent of the deferred group. Results were even better among younger, early-onset diabetic patients: 36 compared with 12 per cent. The study, from 16 major medical centers, appears in the November 1985 issue of the *Archives of Ophthalmology*. This study documents that early intervention "provides a better chance for prompt recovery of useful vision."

• • •

While growth hormone can correct short stature, it does not necessarily assure a normal productive life, according to a report in the November 1985 issue of the *American Journal of Diseases of Children*. In a study of 116 Canadian adults who had been treated with growth hormone, researchers found that unemployment rates were much higher and that marriage rates were much lower than national norms. The study included 86 men and 30 women between the ages of 18 and 38, most of whom had completed formal education comparable to their siblings and peers. Among the findings: 25.4 per cent were unemployed with rates for those younger than 25 years of age 45 per cent and those 25 years and older 23 per cent. National averages for these age groups were 21.2 per cent and 9.4 per cent respectively. The percentage of those married was less than 30 per cent of the expected age-adjusted rate.

"Before treatment, children with growth hormone deficiency have been described as being socially isolated and psychologically immature," say Doctor Heather J. Dean and her colleagues from the University of Manitoba in Winnipeg. "After one or two years of growth therapy, many of these children have persistent severe personality difficulties despite increased linear growth."

Their evaluation of the social outcome of treated patients underscores severe therapeutic failings. Of the 90 patients not attending school, 70

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still lived with parents or relatives. Puberty occurred spontaneously in 63 per cent of the patients. The remaining 37 per cent were receiving sex steroid replacement therapy at the time of the study. Only 13 per cent were married as compared with the national average of 71.1 per cent for their age group, and only 55 per cent of the unmarried patients were dating regularly.

The researchers conclude that new patient management strategies are needed, including the design of specific goal-oriented psychotherapeutic programs. "Since increased height does not necessarily lead to normal social integration in adult life, the goals of growth hormone therapy for normal short children must be carefully, but urgently, evaluated in view of the future unlimited supply of growth hormone produced by recombinant DNA technology."

• • •

A report of a fatal bacterial infection after a blood transfusion appears in the November 1985 issue of the *Archives of Pathology and Laboratory Medicine*, prompting an editorial warning to physicians to be alert to bacterial as well as other blood contaminants. Dr. D. Craig Wright and his colleagues from the Walter Reed Army Medical Center in Washington, DC report on a 61-year-old bypass patient who received blood contaminated with *Yersinia enterocolitica*, which led to septic shock and death. While uncommon, bacterial blood contamination clearly can be as dangerous as contamination by hepatitis or HTLV-III viruses, comments Doctor Byron A. Myhre of the UCLA School of Medicine. "A considerable portion of these reactions are preventable by good history-taking and good technique," he adds.

• • •

Air bags should be available as an option on new cars and should be used in addition to lap-and-shoulder safety belts, according to a new report by the American Council on Science and Health (ACSH). The Council is an independent, nonprofit consumer education organization promoting scientifically balanced evaluations of food, chemicals, the environment, and health.

"Many people are killed or injured unnecessarily in traffic accidents because they are not protected by any restraint system. The use of either seat belts or air bags could prevent many of these tragedies. However, the quickest and least expensive solution to this problem is to make sure that people use the safety belts that are already present in their automobiles," said ACSH Re-

search Associate Sharon Lynn Campbell, author of the report *Automobile Occupant Restraint Systems*.

"Safety belts have been proven effective in reducing death and injuries," Ms. Campbell said, and added, "Several states now require their use, and we think that these laws are reasonable. In those states and foreign countries where mandatory seat belt use laws have been introduced and adopted, seat belt use has increased substantially, and traffic fatalities have dropped."

Because of their expense, the Council recommends that air bags not be required on all new cars. Moreover, since air bags offer protection only in frontal crashes and not in rear-end, broadside, or rollover collisions, they should not be regarded as an alternative to seat belts.

All fifty states and the District of Columbia now require that infants and small children be protected by federally-approved child restraints when they ride in automobiles. "Child safety seats are crucial for the protection of infants and small children," Ms. Campbell said. "The number one killer of children is automobile collisions, and children are at much greater risk of being killed or seriously injured in a crash if they are unrestrained. Children are even more likely to be hurt than adults are, because they are top-heavy and thus at risk of serious head and spinal injuries. Adult seat belts are designed for an adult's center of gravity and do not provide adequate protection for small children."

• • •

An average of 32 per cent of more than 800 patients admitted yearly to a community hospital intensive care unit could have been managed safely in a less intensive and less costly hospital environment, according to a study in the November 1985 issue of the *Archives of Surgery*. Doctor J. Burdette Nelson of the Riverside (California) Community Hospital conducted a ten-year retrospective review of admissions to a surgical intensive care unit, comparing hospital admission practices, monitoring parameters, and lengths of stay with those of published reports. He urges surgeons to work with hospital administrators to establish intermediate care units "so that patients will not be jeopardized by the impending fiscal constraints" of proposed new prospective payment systems based on diagnostic-related groups.

• • •

The diagnosis of primary antisocial personality disorder with a secondary diagnosis of alcoholism indicates a poor prognosis for alcohol, drug, and social problems, according to a new report in the

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November 1985 issue of the *Archives of General Psychiatry*. Doctor Marc A. Shuckit from the University of California at San Diego studied 577 consecutive men entering an alcohol treatment program at a veterans hospital and assigned them to one of four groups. Most had primary drug abuse problems; a third had primary antisocial personality problems; and a fourth had primary affective disorders. "During the follow-up, men in the second and third groups had a greater likelihood of drug use, more police and social problems, and demonstrated more adverse outcomes on a clinical outcome scale," says Shuckit.

• • •

A new technological development in the treatment of back pain has emerged through the collaborative efforts of American and Swedish health professionals. The Auto-Traction Table® has been developed by Doctor Emil Natchev and a US team of physical therapists from the American Physical Therapy Association, West Virginia University, and the Chattanooga Company. This new method of treatment is different from traditional methods in that a newly-injured person can be treated on the same day as his injury occurs. With traditional methods a patient generally has had to wait several days before starting treatment.

The patient is placed on the table usually in a standing position and is then lowered into a prone position. The table is built in sections so that it can be adjusted until the patient is in a completely pain-free position. Once this pain-free position is found, the table with the patient is returned to a standing position. The first treatment on the Auto-Traction Table® requires approximately an hour. Most patients require four or five subsequent treatments on the table to maintain their pain-free status.

Back injuries in this country are the leading cause of work days lost with more than 2.5 million cases reported each year. The amount spent annually on such injuries is $2.8 billion with an average of $4,600 spent on each case.

• • •

Hay fever is the most common allergic disease in this country, affecting between 18 and 20 million Americans, according to the report *Hay Fever*, published by the American Council on Science and Health (ACSH). The Council is an independent, nonprofit consumer education organization promoting scientifically balanced evalua-

tions of food, chemicals, the environment, and health. It may also be one of the most misunderstood diseases, and the confusion starts with its name. The allergic reaction is rarely associated with hay, and fever is not one of its symptoms, the report states.

"One common myth is that colorful, sweet-smelling flowers that attract insects are the major culprits in hay fever," said Doctor Alan Fisher, co-author of the ACSH report. "However, these plants actually have heavy pollen grains which don't easily become airborne. The real villains are plants that often go unnoticed because they are dull-looking and odorless."

Some hay fever sufferers buy air cleaning systems to filter dust, pollen, or mold spores from the air in their homes. However, filtering devices that attach to central heat and air conditioning systems can be expensive, the ACSH report warns, and portable devices may be good only for a small area. Most portable devices filter only pollen, not spores, so that they are of limited value to individuals who are allergic to mold spores. ACSH advises consumers to read labels carefully when purchasing such a machine and to make sure that the device is approved by the US Food and Drug Administration for allergies.

• • •

The American College of Emergency Physicians (ACEP) has called for a total ban on tobacco advertising. While cigarette advertising was banned from television in 1971, the cigarette industry spends more than $1 billion a year on print advertising, more than any other product. The College also favors an immediate end to government subsidies to the tobacco industry. Ending these subsidies would place the tobacco farming industry in a competitive situation, causing tobacco prices to rise and possibly discouraging nonsmokers from starting the habit. Moreover, ACEP supports raising taxes on tobacco products and devoting the revenue to the care of patients with tobacco-use-related disease. The organization also is encouraging the prohibition of tobacco smoking in public places except designated areas. Finally, the College endorses continued use of honest and accurate warnings, such as package inserts, on all tobacco products. "By providing package inserts in all tobacco products, tobacco users would be supplied with more in-depth information about the medical effects of smoking," said Doctor Richard L. Stennes, ACEP President.

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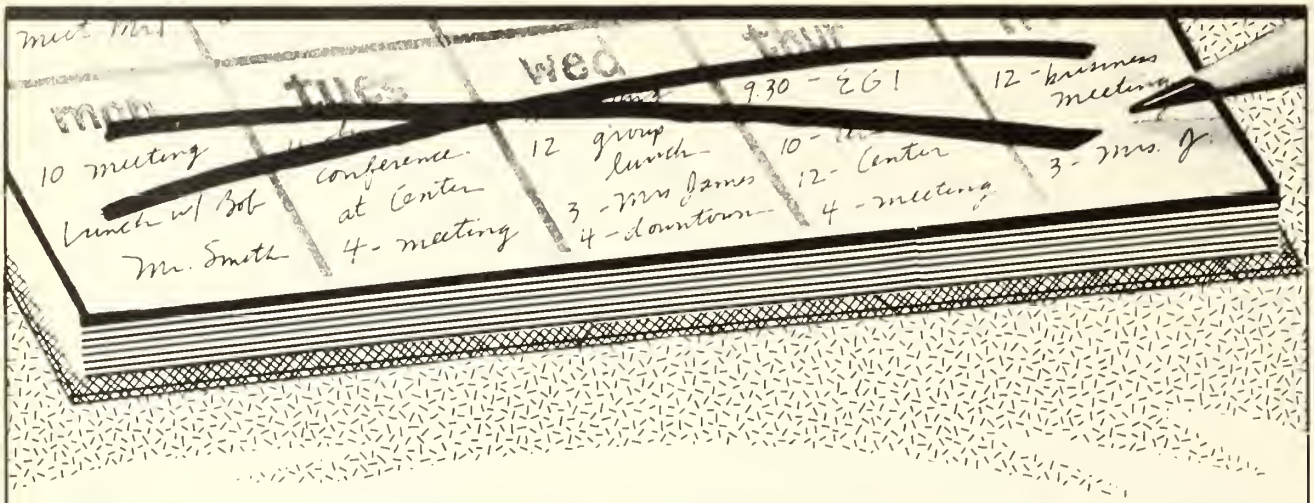
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LETTERS TO THE EDITOR

Caring

To the Editor:
Congratulations and thank you for your editorial, "Caring" (*Rhode Island Medical Journal,* January 1986). This should be required reading for every doctor from the first day of medical school until the day of retirement. Not a bad idea for the editorial to be required reading annually at the time of licensure renewal.

Kenneth G. Burton, MD

To the Editor:
I am writing in response to your editorial on caring. The physicians of today have compassion and empathy for their patients just as did the physicians of fifty years ago. Caring is as much a part of modern medicine as technology.

The practice of obstetrics has had dramatic changes over the past two decades. It is true that we have had many technologic advances including fetal monitoring, fetal scalp blood monitoring, amniocentesis, and ultrasonography. In addition social changes have occurred which have involved the patient and family in the birthing process. Family-oriented practice is the norm in modern obstetrics. The patient and husband share the birth experience. In all deliveries husbands or significant others are in attendance, including caesarian sections. The patient and family have become more involved in decision-making as it pertains to obstetrics. Years ago, the obstetrician made all the decisions and consulted the husband after the birth.

In spite of these developments, there is a malpractice crisis in obstetrics. More than 75 per cent of all obstetricians in the United States have had at least one lawsuit. I am not saying that we should abandon family-oriented obstetrics or a good bedside manner, but it should be noted that these qualities will not prevent malpractice suits.

Thomas A. Vest, MD

(The presence of husbands or significant others — whoever they may be — in the delivery room is not universally welcomed and may or may not involve the caring of the physician. We do not believe that the problem of caring alone has created the malpractice crisis, but it is certainly a relevant issue. Ed.)

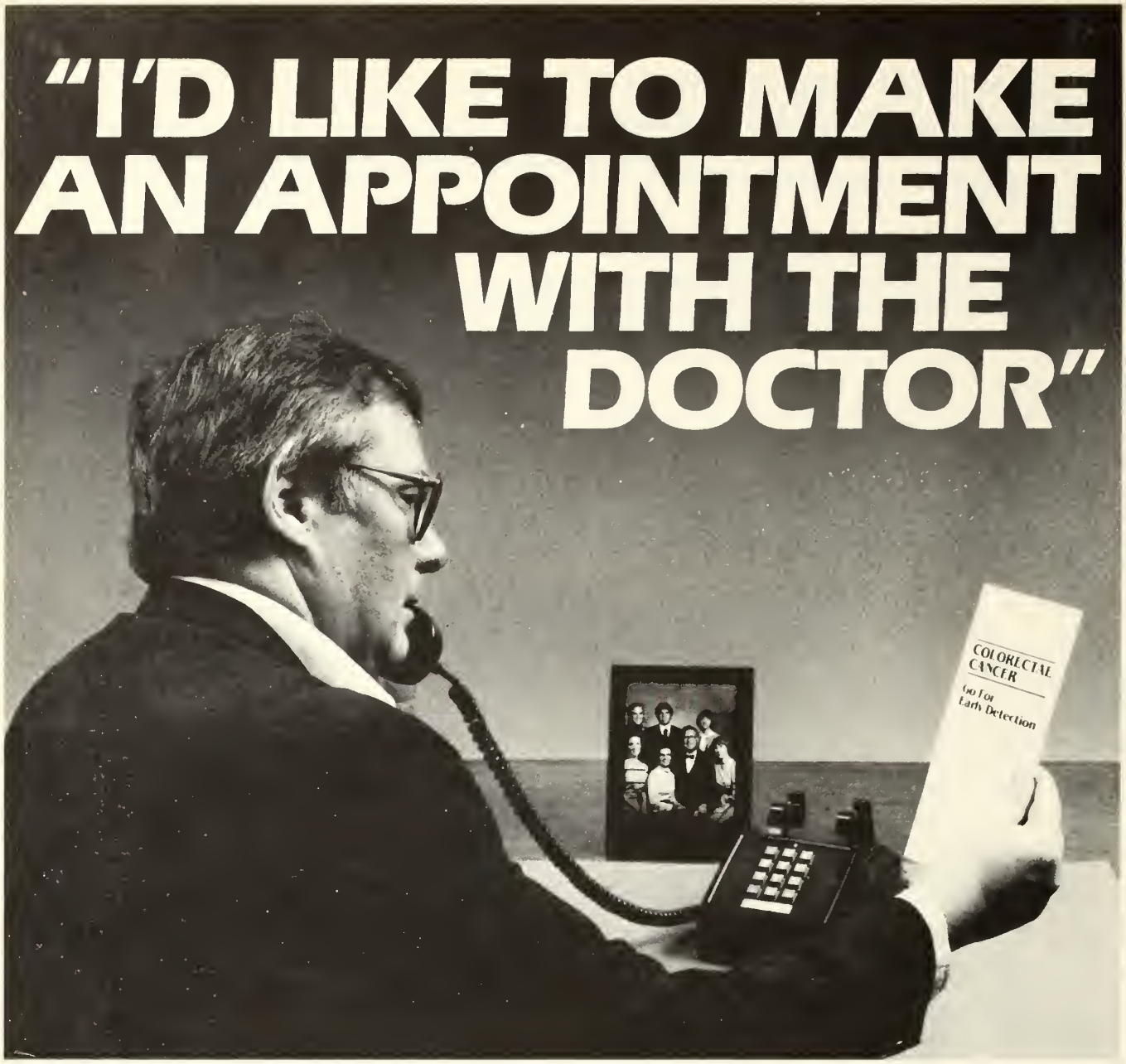
To the Editor:
I very much enjoyed and agreed with your editorial on caring. You mentioned that physicians often seem "disinterested" in their patients where I think you mean "uninterested." Disinterest indicates fairness and impartiality, probably good qualities for physicians, especially given the financial pressures applied to us to cut costs these days.

Your first two paragraphs state the problem well. The solution you offer in the last paragraph, exhorting hospitals and medical schools to inculcate a "cult of caring" is worth expanding on in future articles and editorials. Assuming that most doctors do "care," how can you make them seem that way outwardly?

Doctor John Winage, course leader of Brown's BioMed 390 (interviewing techniques for first-year students), has some very good simple tips even for the smoothest physician. They address how to show "caring" for a patient through body language, etiquette and manners, and a system for responding appropriately to a distressed individual.

Allen M. Dennison, MD

(Our columns surely are open for more on this subject. While purists have long frowned upon the use of "disinterested" for "uninterested," recent dictionaries have given it respectability. Widely used, it is probably here to stay. Ed.)



Be prepared, Doctor. More patients will be asking about colorectal cancer. According to a survey* conducted by the American Cancer Society, many people would like to receive more information about colorectal cancer, and 83% said they would want to be checked for it. Further, they are learning that this cancer can be detected *before* symptoms appear. The present cure rate is 44%. The cure rate *could* be as high as 75%, with early detection and appropriate management.

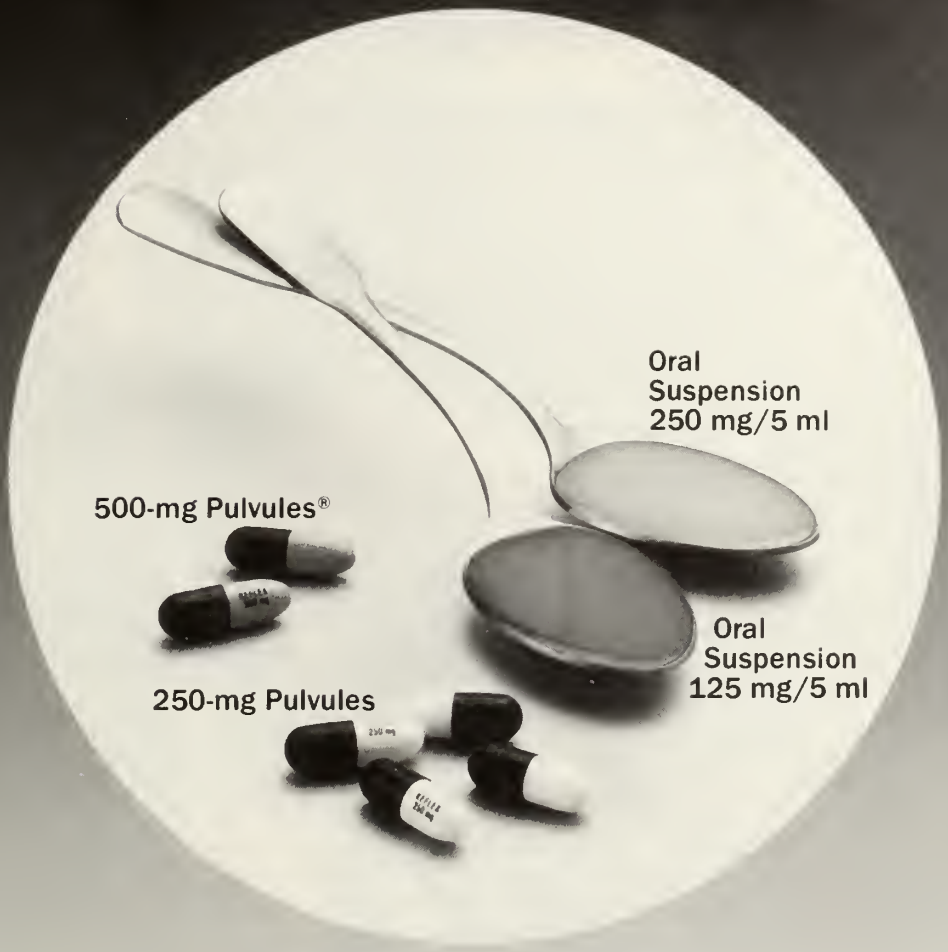
For asymptomatic persons the Society recommends annual digital rectal examination at age 40 and over; at age 50 and over, an annual stool blood test, as well as sigmoidoscopy every three to five years, following two initial annual negative sigmoidoscopies.

We're here to help. You can reach us at your local American Cancer Society office or write to our Professional Education Department at National Headquarters, 90 Park Avenue, New York, N.Y. 10016. Ask about the Society's Colorectal Check program of professional and public education for the early detection of colorectal cancer.

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*"Cancer of the Colon and Rectum: Summary of Public Attitude Survey," *Ca* 33:359-365, 1983 (Nov.-Dec.).

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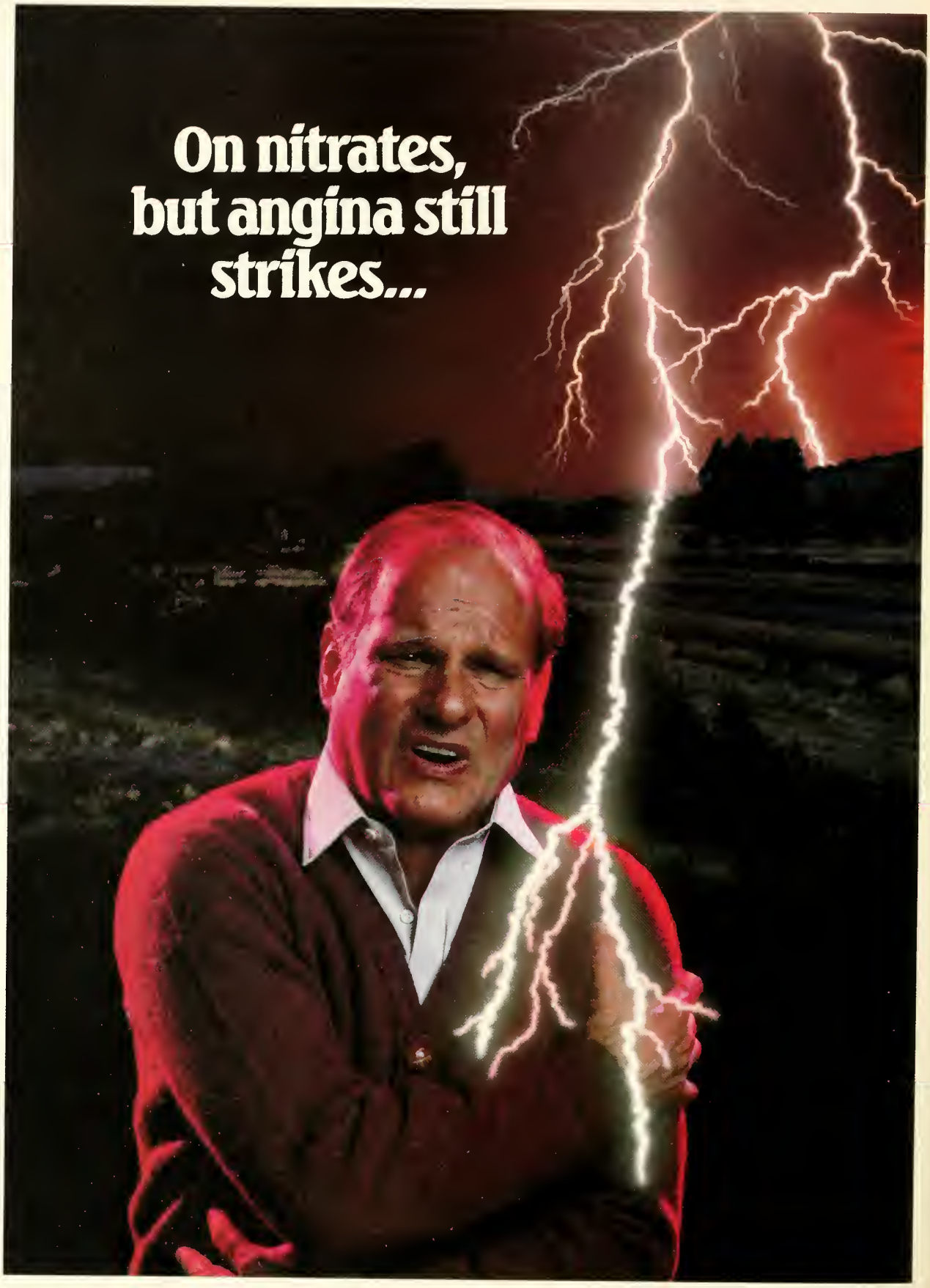
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Please see brief summary on following page.

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Contraindications: Severe left ventricular dysfunction (see *Warnings),* hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (except in patients with a functioning artificial ventricular pacemaker), 2nd- or 3rd-degree AV block. **Warnings:** ISOPTIN should be avoided in patients with severe left ventricular dysfunction (e.g., ejection fraction < 30% or moderate to severe symptoms of cardiac failure) and in patients with any degree of ventricular dysfunction if they are receiving a beta blocker. (See *Precautions.)* Patients with milder ventricular dysfunction should, if possible, be controlled with optimum doses of digitalis and/or diuretics before ISOPTIN is used. (Note interactions with digoxin under *Precautions.*) ISOPTIN may occasionally produce hypotension (usually asymptomatic, orthostatic, mild and controlled by decrease in ISOPTIN dose). Elevations of transaminases with and without concomitant elevations in alkaline phosphatase and bilirubin have been reported. Such elevations may disappear even with continued treatment, however, four cases of hepatocellular injury by verapamil have been proven by rechallenge. Periodic monitoring of liver function is prudent during verapamil therapy. Patients with atrial flutter or fibrillation and an accessory AV pathway (e.g. W-P-W or L-G-L syndromes) may develop increased antegrade conduction across the aberrant pathway bypassing the AV node, producing a very rapid ventricular response after receiving ISOPTIN (or digitalis). Treatment is usually D.C.-cardioversion, which has been used safely and effectively after ISOPTIN. Because of verapamil's effect on AV conduction and the SA node, 1° AV block and transient bradycardia may occur. High grade block, however, has been infrequently observed. Marked 1° or progressive 2° or 3° AV block requires a dosage reduction or, rarely, discontinuation and institution of appropriate therapy depending upon the clinical situation. Patients with hypertrophic cardiomyopathy (IHSS) received verapamil in doses up to 720 mg/day. It must be appreciated that this group of patients had a serious disease with a high mortality rate and that most were refractory or intolerant to propranolol. A variety of serious adverse effects were seen in this group of patients including sinus bradycardia, 2° AV block, sinus arrest, pulmonary edema and/or severe hypotension. Most adverse effects responded well to dose reduction and only rarely was verapamil discontinued. **Precautions:** ISOPTIN should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of excessive pharmacologic effects. Studies in a small number of patients suggest that concomitant use of ISOPTIN and beta blockers may be beneficial in patients with chronic stable angina. Combined therapy can also have adverse effects on cardiac function. Therefore, until further studies are completed, ISOPTIN should be used alone, if possible. If combined therapy is used, close surveillance of vital signs and clinical status should be carried out. Combined therapy with ISOPTIN and propranolol should usually be avoided in patients with AV conduction abnormalities and/or depressed left ventricular function. Chronic ISOPTIN treatment increases serum digoxin levels by 50% to 70% during the first week of therapy, which can result in digitalis toxicity. The digoxin dose should be reduced when ISOPTIN is given, and the patients should be carefully monitored to avoid over- or under-digitalization. ISOPTIN may have an additive effect on lowering blood pressure in patients receiving oral antihypertensive agents. Disopyramide should not be given within 48 hours before or 24 hours after ISOPTIN administration. Until further data are obtained, combined ISOPTIN and quinidine therapy in patients with hypertrophic cardiomyopathy should probably be avoided, since significant hypotension may result. Clinical experience with the concomitant use of ISOPTIN and short- and long-acting nitrates suggest beneficial interaction without undesirable drug interactions. Adequate animal carcinogenicity studies have not been performed. One study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. *Pregnancy Category C:* There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor and delivery only if clearly needed. It is not known whether verapamil is excreted in breast milk; therefore, nursing should be discontinued during ISOPTIN use. **Adverse Reactions:** Hypotension (2.9%), peripheral edema (1.7%), AV block: 3rd degree (0.8%), bradycardia: HR < 50/min (1.1%), CHF or pulmonary edema (0.9%), dizziness (3.6%), headache (1.8%), fatigue (1.1%), constipation (6.3%), nausea (1.6%), elevations of liver enzymes have been reported. (See *Warnings.*) The following reactions, reported in less than 0.5%, occurred under circumstances where a causal relationship is not certain: ecchymosis, bruising, gynecomastia, psychotic symptoms, confusion, paresthesia, insomnia, somnolence, equilibrium disorder, blurred vision, syncope, muscle cramp, shakiness, claudication, hair loss, macules, spotty menstruation. **How Supplied:** ISOPTIN (verapamil HCl) is supplied in round, scored, film-coated tablets containing either 80 mg or 120 mg of verapamil hydrochloride and embossed with "ISOPTIN 80" or "ISOPTIN 120" on one side and with "KNOLL" on the reverse side. Revised August, 1984 2385

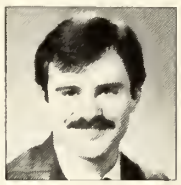
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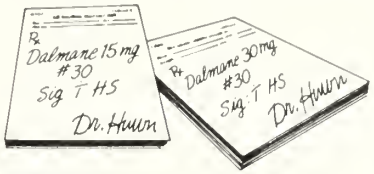
The recommended dose in elderly or debilitated patients is 15 mg. Contraindicated in pregnancy.

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References: **1.** Kales J, *et al Clin Pharmacol Ther 12* 691-697, Jul-Aug 1971 **2.** Kales A, *et al Clin Pharmacol Ther 18*:356-363, Sep 1975. **3.** Kales A, *et al Clin Pharmacol Ther 19* 576-583, May 1976 **4.** Kales A, *et al Clin Pharmacol Ther 32* 781-788, Dec 1982 **5.** Frost JD Jr, DeLucchi MR *J Am Geriatr Soc 27* 541-546, Dec 1979 **6.** Dement WC, *et al Behav Med*, pp. 25-31, Oct 1978 **7.** Kales A, Kales JD *J Clin Psychopharmacol 3* 140-150, Apr 1983 **8.** Tennant FS, *et al* Symposium on the Treatment of Sleep Disorders, Teleconference, Oct 16, 1984 **9.** Greenblatt DJ, Allen MD, Shader RI. *Clin Pharmacol Ther 21* 355-361, Mar 1977.



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Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Withdrawal symptoms rarely reported; abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase, and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect. *Adults*: 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients*: 15 mg recommended initially until response is determined.

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Rhode Island Medical Journal

April 1986
Volume 69, Number 4

[redacted]

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Spring comes to Rhode Island as the General Assembly whips into action — See page 141

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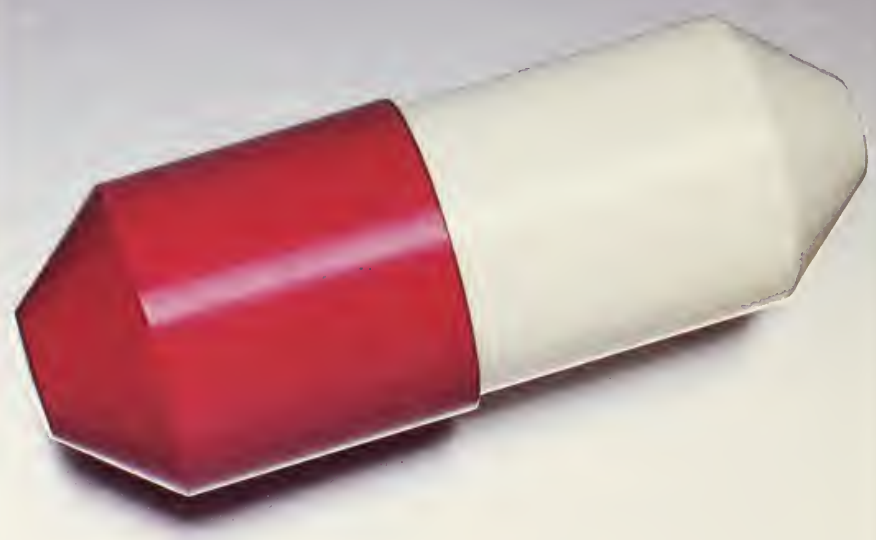
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J-6138 January 1986

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Before prescribing, see complete prescribing information in SK&F CO. literature or *PDR*. The following is a brief summary.

* WARNING

This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Contraindications: Concomitant use with other potassium-sparing agents such as spironolactone or amiloride. Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

Precautions: The bioavailability of the hydrochlorothiazide component of 'Dyazide' is about 50% of the bioavailability of the single entity. Theoretically, a patient transferred from the single entities of Dyrenium (triamterene, SK&F CO.) and hydrochlorothiazide may show an increase in blood pressure or fluid retention. Similarly, it is also possible that the lesser hydrochlorothiazide bioavailability could lead to increased serum potassium levels. However, extensive clinical experience with 'Dyazide' suggests that these conditions have not been commonly observed in clinical practice. Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids, and during concurrent use with amphotericin B or corticosteroids or corticotropin [ACTH]). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Cumulative effects of the drug may develop in patients with impaired renal function. Thiazides should be used with caution in patients with impaired hepatic function. They can precipitate coma in patients with severe liver disease. Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic and hemolytic anemia have been reported with thiazides. Thiazides may cause manifestation of latent diabetes mellitus. The effects of oral anticoagulants may be decreased when used concurrently with hydrochlorothiazide; dosage adjustments may be necessary. Clinically insignificant reductions in arterial responsiveness to norepinephrine have been reported. Thiazides have also been shown to increase the paralyzing effect of nondepolarizing muscle relaxants such as tubocurarine. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. Triamterene has been found in renal stones in association with the other usual calculus components. Therefore, 'Dyazide' should be used with caution in patients with histories of stone formation. A few occurrences of acute renal failure have been reported in patients on 'Dyazide' when treated with indomethacin. Therefore, caution is advised in administering nonsteroidal anti-inflammatory agents with 'Dyazide'. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia is uncommon with 'Dyazide', but should it develop, corrective measures should be taken such as potassium supplementation or increased dietary intake of potassium-rich foods. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Concurrent use with chlorpropamide may increase the risk of severe hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function.

Thiazides may add to or potentiate the action of other antihypertensive drugs.

Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances; postural hypotension (may be aggravated by alcohol, barbiturates, or narcotics). Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and respiratory distress including pneumonitis and pulmonary edema, transient blurred vision, sialadenitis, and vertigo have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components. Rare incidents of acute interstitial nephritis have been reported. Impotence has been reported in a few patients on 'Dyazide', although a causal relationship has not been established.

Supplied: 'Dyazide' is supplied as a red and white capsule, in bottles of 1000 capsules; Single Unit Packages (unit-dose) of 100 (intended for institutional use only); in Patient-Pak™ unit-of-use bottles of 100.

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RHODE ISLAND MEDICAL SOCIETY
April 1986

Newsletter

Herbert Rakatansky, MD, President
Wendy J. Smith, Editor

MALPRACTICE COMMISSION DEVELOPS PROPOSAL

The Legislative Commission on Medical Malpractice recently approved a 30-point legislative package intended to alleviate the malpractice crisis. Nearly two-thirds of the proposed recommendations address the Board of Medical Review, the state disciplinary agency for physicians.

Calling the Board "a miserable failure in policing the performance of Rhode Island physicians," Commission chairman Senator Michael Forte (D, Tiverton) called for a new Board of Medical Licensure and Discipline which would have combined licensure and disciplinary functions. Although the new board would operate under the aegis of the Rhode Island Department of Health, the Commission recommended that it be autonomous in funding and professional decision-making. The Board would be given new powers and funding to investigate complaints and malpractice settlements or awards against physicians. The new board would be financed by an annual assessment of up to $300 for physicians. Governor Edward D. DiPrete introduced a similar proposal earlier in the session.

The Commission also adopted the recommendation of the Rhode Island Medical Liability Coalition that hospital peer review and credentialling activities conducted in good faith be exempted from state and federal antitrust laws. This follows the findings of an Indiana case, Marrese v Intergual, Inc, in which a federal court rule that proceedings which could result in the revocation of an orthopedic surgeon's clinical privileges were exempt from federal antitrust laws under the doctrine of state action.

Also included in the Commission's package were the following proposals:

- Prejudgment interest would accrue from the date a suit is filed or formal notification of a suit is given rather than from the date of the alleged incident.
- Expert witnesses would be board certified in the appropriate specialty.
- Plaintiffs filing frivolous suits would be responsible for the defendant's legal expenses.
- Periodic payments for awards greater than $100,000 would be considered.
- The collateral source rule would be amended to preclude duplicate payments.
- Cases with a potential for substantial settlements would be placed on an accelerated court schedule.

RIMS President Doctor Herbert Rakatansky emphasized that the Commission's action provides only a starting point for significant tort reform. The Commission notably failed to act regarding caps on awards for pain and suffering or limits on attorneys' contingency fees. The Society and the Medical Liability Coalition had recommended a $250,000 cap on awards for non-economic losses and that contingency fees be limited on a sliding scale with ten per cent of all awards greater than $200,000.

The Legislative Commission on Medical Malpractice was appointed by the General Assembly in 1984 in lieu of acting on a five-part malpractice reform package introduced by the Society. The Commission heard testimony from physicians, attorneys, the Joint Underwriting Association, the Board of Medical Review, legal expert Jeffrey O'Connell from the University of Virginia, consumer advocate Ralph

MALPRACTICE COMMISSION (continued)

Nader, and hospitals. The 18-member Commission included eight attorneys; three physicians; one judge; one insurance claims manager; one hospital association executive; one housewife; one retardation center executive; and two college professors. The physicians serving on the Commission were Doctors Herbert Rakatansky, RIMS President; Paul J.M. Healey, immediate past president; and Frank M. D'Alessandro.

GENERAL ASSEMBLY WHIPS INTO ACTION

More than 100 bills affecting health, medical care, and physician reimbursement were submitted to the Rhode Island General Assembly before the March 7 closure date for filing. To become law, bills must be heard by the appropriate committees in the Senate and House of Representatives, approved by both the House and the Senate, and signed by the governor within six days of passage. Although the General Assembly is scheduled to adjourn May 16, knowledgeable observers predict that the 1986 session will not end until early June.

Bills of special interest to physicians include:

Malpractice: In addition to the 30-point legislative package submitted by the Legislative Commission on Medical Malpractice (see page 140), Senator Michael J. Flynn has introduced a bill which would place a $250,000 cap on awards for pain and suffering, impose an eight per cent limit on prejudgment interest, restrict attorneys' contingency fees, exempt hospital medical staff credentialling processes from antitrust restrictions, and provide for the confidentiality of medical staff records.

S. 2468 (Motherway) would restrict attorneys' contingency fees in medical malpractice cases to 40 per cent of the first $50,000, 33-1/3 of the next $50,000, 25 per cent of the next $100,000, and 10 per cent of all awards greater than $200,000.

Reimbursement: Three bills have been introduced which would require physicians to accept assignment of benefits as payment in full for all Medicare beneficiaries. H 7982, introduced by Representative Francis Sherman, would require the acceptance of assignment as a condition of licensure. Another bill, also sponsored by Sherman, would define balance billing under Medicare as "unprofessional conduct." The Society has informed the sponsors of these bills that they would violate federal Medicare regulations. It also was pointed out that reimbursement practices should have no role in the eligibility for licensure as they are not relevant to qualifications. The constitutionality of a similar law in Massachusetts which links Medicare assignment with licensure is being contested. In addition, H 7227 (Cardente) would require physicians to post their fees in conspicuous places.

Living wills: S 2284 (Sabatini) would provide a mechanism for establishing rights of the terminally ill, including the decision to have life-sustaining measures withheld or withdrawn. A nearly identical bill, S 2311 (Farnum), also would establish a living will mechanism for the state. H 7724 (Carcieri) would create a durable power of attorney for health care purposes.

AIDS: H 7015 (DeLuca) would require the Department of Health to establish clinics to educate the public on the prevention of acquired immune deficiency syndrome (AIDS) and to treat victims. It also would empower the health department to regulate any organization which receives blood donations. Another bill (H 7024) would add screening for AIDS to the required blood tests for marriage licenses.

Smoking: H 7031 (Rossi) would ban the sale of tobacco products to minors. Another bill (H 7149) would prohibit the sale of snuff to minors and would require warning labels on all packages of chewing tobacco sold in the state.

Drugs: H 7026 (DeLuca) would expand the Rhode Island Pharmaceutical Assistance to the Elderly program. On a related matter, H 7088 (Cardente) would increase the income limitations for eligible recipients to $10,000 for single persons and $15,000 for couples. Eight other bills would expand the types of drugs covered under the program.

GENERAL ASSEMBLY (continued)

Seat belts: Three House bills and two Senate bills would impose a $25 fine for failure to use seat belts. On a lighter note, one bill would require all shopping carts to be equipped with seat belts.

Medical records: Under H 7643 (Friedemann) hospitals would be required to maintain all patient records for 15 years and hospital ambulatory clinics for ten years. H 7057 (DeLuca) would permit unlimited patient access to medical records.

Mental health: H 7101 (Cardente) would require all mental health agencies which receive state funds to delete the words "mental health" from their titles and substitute "counseling." H 7567 (Teitz) would extend the authority of the mental health advocate to clients of community mental health centers. Dealing with alcoholism, S 2488 (Badeau) would permit persons to seek voluntary treatment of alcoholism only once during every two year period.

Other bills of interest to physicians include:

- H 7268 (Cardente) - would provide for a three year transition of the present certificate-of-need thresholds to the corresponding minimum federal levels
- H 7412 (Batastini) - would require hospital officials to approach families of deceased patients for anatomical donations
- H 2221 (D'Ambra) - would establish educational, training, and practice requirements for respiratory therapists
- H 7555 (DeLuca) - would require all hospitals to establish a patient transfer policy under guidelines promulgated by the Department of Health
- H 7619 (Friedemann) - would establish 911 as the primary emergency telephone number and would provide emergency communications procedures for calls for fire, police, medical, rescue, and other emergency services
- H 7734 (Tsiongas) -- would create a scholarship and loan program for third and fourth year medical students.

NATIONAL TORT REFORM COALITION FORMED

More than 960,000 businesses, professionals, and public entities -- represented by 24 organizations, including the American Medical Association -- have formed the American Tort Reform Association, the first coalition of its kind devoted solely to reforming the US civil justice system.

In announcing the coalition's formation, ATRA president Jim Coyne called for an end to "litigation pollution." According to Coyne, "We must return to a rational, logical justice system, where plaintiffs receive awards because they prove someone has been negligent and harmed them." Coyne, who is also executive vice-president of the American Consulting Engineers Council, says that ATRA will work to reform lawyers' contingency fees, limit awards for non-economic losses, and restrict the use of joint and several liability. The group also wants appropriate statutes governing collateral sources of payments. "Excessive litigation is a tragic American disease," said Coyne, who added, "It's severely damaging our public and private sectors and, at the same time, reducing the ability of legitimate plaintiffs to get quick and fair disposition of their claims.

As the tort liability crisis has extended to all kinds of activities, it may result that the solution to the malpractice crisis lies elsewhere than in specific class legislation.

GOVERNOR'S COUNCIL CHARGED WITH ADDRESSING INSURANCE LIABILITY CRISIS

Governor Edward D. DiPrete has charged a group of insurance executives with finding ways to resolve a crisis in the insurance industry that has led to such high rates for certain types of liability insurance that many purchasers are unable to afford coverage.

DiPrete said the findings of the Governor's

STATE COALITION (continued)

Insurance Council should "go a long way" toward overall improvement of the state's business climate, which he has set as a priority of his administration. The panel of 25 executives, all appointed by DiPrete, includes the directors of the state departments of Business Regulation and Economic Development and a member of the governor's policy staff.

The Council has been charged with addressing three issues: studying the availability and affordability of liability insurance, fostering a business climate that helps insurance companies in Rhode Island to prosper, and attracting additional companies to the state.

The Council's formal report is expected by May. DiPrete said that recommendations he supports will be implemented administratively or, if necessary, submitted to the General Assembly next year for approval.

RIPAE PROGRAM COVERS CERTAIN DRUGS

The Rhode Island Pharmaceutical Assistance to the Elderly (RIPAE) program covers 60 per cent of the cost of certain medications for diabetes, high blood pressure, and cardiovascular functions. The patient pays the remaining 40 per cent. To be eligible, a patient must be 65 years of age or older and have an income of $9,000 or less for single persons or $12,000 for couples.

Applications for the RIPAE program are available from the Department of Elderly Affairs at 401/277-2880.

PERCENTAGE OF SMOKING RHODE ISLAND PHYSICIANS DECLINES

The percentage of physicians in Rhode Island who smoke cigarettes has declined to eight per cent from 33 per cent twenty years ago, according to the Rhode Island Department of Health.

The survey, reported in the March 1986 issue of the Journal of Public Health, covered 82 per cent of the state's 2,200 physicians and showed:

- Only 4.5 per cent of physicians under 30 years of age smoke.
- Some 6.3 per cent of physicians under age 35 smoke; 12.3 per cent of those over 75 smoke.
- Among specialties, obstetricians and gynecologists had the highest smoking rate - 14 per cent - while otolaryngologists had the lowest - 3.8 per cent.

NEW AMA PUBLICATION

The AMA Department of Physician Practice Services recently has published a new booklet called Medical Practice Finance: A Guide for Physicians. Prepared with th assistance of the accounting firm Arthur Young & Company, the publication is oriented toward physicians who plan to ob tain financing to establish or expand a medical practice. Chapters include: pre paring yourself to work with a lender, what your lender needs to know, debt and equity financing, financing approaches, case studies, sample practice plan, sampl loan applications, and sources of additio al information.

It is available to AMA members for $9.95 per copy and to nonmembers for $14.95. Orders should be placed through Book and Pamphlet Fulfillment - OP 233, American Medical Association, PO Box 10946, Chicago, Illinois 60610.

RIMS ANNUAL MEETING TO BE MAY 30

The 175th Annual Meeting of the Rhode Island Medical Society will be held Friday, May 30, at the Biltmore Plaza Hotel, Providence. Featured will be an after-dinner address by Senator John Chafee. Also included in the day-long session will be the annual meeting of the membership and House of Delegates, the presentation of the 45th Chapin Oration, the Presidential Address by Doctor Herbert Rakatansky, and the inauguration of officers for 1986-1987. The Chapin Orator will be William L. Curran, a frequent contributor to the New England Journal of Medicine. Entertainment will be by the Debbie Waldman Group.

Additional information and registration forms will be sent to the membership later this month. For further information, please call the Society's offices at 401/331-3207.

Rhode Island Medical Journal

April 1986
Volume 69, Number 4

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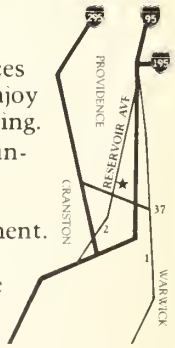
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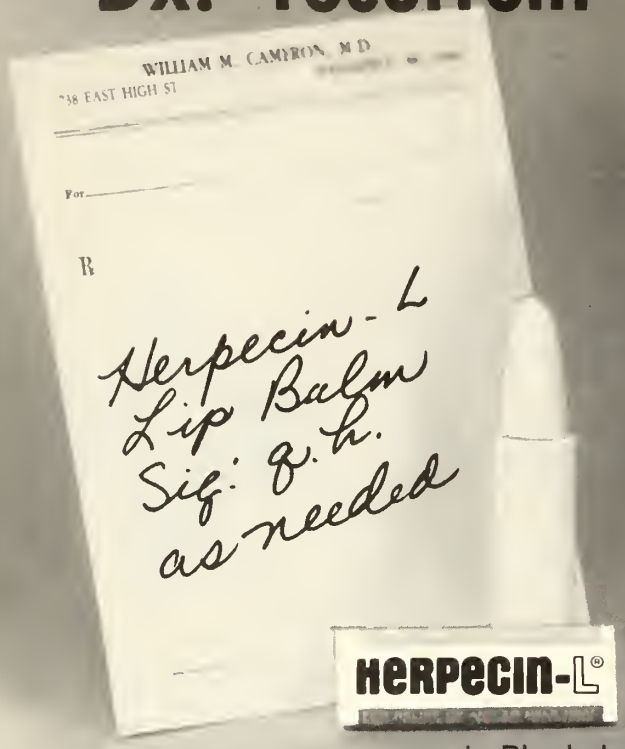
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COVER

Spring comes to Rhode Island as the General Assembly whips into action. See page 141.

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EDITORIAL

The Future of PPS (DRGs)

The prospective payment system (PPS) for hospital reimbursement under the federal Medicare program uses diagnosis-related groups (DRGs) to determine the amount of payment. What effect is this having on the quality of medical care? It is much too early for definitive answers, but the reports are beginning to come in. The signals are mixed.

The American Medical Association and the American Society of Internal Medicine relied on voluntary responses rather than random samples. Complaints are numerous, but whether these can be interpreted as evidence of failure of the system is open to question.

Two statistical studies by respected research firms have elicited pertinent information. Health Economics, Inc, of Chestnut Hill, Massachusetts in a study financed by the Health Care Financing Administration (HCFA) reveals that four out of five physicians perceived that hospitals had induced them to change their practices to accommodate the new payment system. Eighty-five per cent of radiologists, anesthesiologists, and pathologists reported pressure to do more testing on an outpatient basis. More than half had been asked to limit expensive procedures and to perform fewer procedures. Almost eighty per cent of physicians felt that they were urged to discharge patients earlier and to request fewer tests. While the study confirms widespread pressures to alter practice patterns, it leaves unanswered two pertinent questions. How much pressure have hospitals applied and what percentage of physicians yielded to the pressure? It also leaves unanswered the question of outcome — was this harmful to patients? The statistical changes noted, incidentally, were more evident among Medicare than non-federal patients.

The second study was conducted by our old friend, the Commission on Professional and Hospital Activities (CPHA) of Ann Arbor, Michigan. In general the report indicates that a downward trend in hospital use rates is much greater than would have been expected without PPS, and was greater for Medicare than for other patients. The decline in length-of-stay was four times as great as would otherwise have been expected. There were similar effects in the use of intensive and cardiac care units.

Looking to outcome results, the CPHA study found no increases in hospital readmissions and no unexpected increases in discharges to skilled nursing facilities (SNF). There were significant increases, however, in discharges to psychiatric and rehabilitation facilities and to home health care agencies. CPHA states that PPS "appears" to have been effective in reducing some inefficiencies without causing deterioration in the quality of care. It cautions, however, that:

- An observed drop in Medicare inpatient mortality rates may indicate a tendancy to discharge severely ill patients to other locations.
- The increase in discharges to other facilities could signify transfer to facilities not covered by PPS.
- The growing trend to use home health agencies requires very careful monitoring to assure quality of care.
- It is not entirely clear that moving patients out of the hospital to other types of post-hospital care is "a good solution to controlling Medicare costs."

Another study by HCFA itself states that "early evidence indicates that PPS is accomplishing many of its stated objectives without major problems"

— which may, of course, be self-serving. The report, incidentally, noted an increase in the number of discharges to skilled nursing facilities somewhat greater than would otherwise have been expected.

A somewhat different picture emerges from comments by Doctor James I. Glenn, president of the Mount Sinai Medical Center in New York, speaking before the 1985 Clinical Congress of the American College of Surgeons. DRGs, he states, will have an ominous and in many cases adverse impact on all aspects of health care delivery, including the patient, the physicians, medical education, and the overall structure of the health care system. Patients can expect shorter hospitalizations. "In fact, that trend," he states, "is already occurring," with hospital stays down 12 per cent and hospital bed utilization down 10 per cent. A number of other factors are affecting or will affect the health scene, including federal legislation to control the cost of graduate education, the surplus of physicians, and the importation of foreign medical graduates.

As for the impact on patients, he speculates that DRGs may increase personal discomfort, increase patient involvement in their own health care, and increase the complication rate. Studies to date do not yet show an effect on the complication rate, but "the potential is always there." As for surgeons, more time will have to be devoted to care in the ambulatory sector and to such administrative functions as the scheduling of diagnostic tests. There is an associated greater potential for the kind of confusion that enhances the malpractice risk. Diminishing bed usage will inevitably increase the per diem overhead costs as hospital services must remain essentially the same.

An unpleasant adversarial relationship will undoubtedly develop between hospitals and physicians if lump sum reimbursement, including the physician's fee, is initiated.

There will be a deleterious impact on medical education if the federal government through tailoring of DRGs withdraws from responsibility for undergraduate medical education. The current "rumblings," he continues, about graduate medical education may suggest that the government will seek to remove itself from these costs as well." Doctor Glenn foresees a cholescystectomy case being worked up on an ambulatory basis, admitted directly to the operating room (where the resident will see the patient for the first time as a "small patch of skin in the right upper quadrant"), sent to the recovery room, then to a step-down unit, and out of the hospital on the fourth day. "There's certainly not much of a learning experience in this scenario," he states and adds, "We are now technologically dependent and economically hostage to the fact that we can no longer afford the luxury of teleological bedside teaching, and I think both the patient and physician will suffer as a result:" He quoted Congressman Henry Waxman regarding planning for the future: "The federal government keeps changing the rules every year and breaking promises. It is exceedingly difficult for the health care system to design its own policies in the face of the government's constantly shifting policies."

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Seebert J. Goldowsky, MD

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PRESIDENT'S PAGE

Representation

One of the more common topics in conversation I have had with colleagues this year is the issue of how well the Rhode Island Medical Society represents the individual doctor. In the eyes of the public, the Society represents all of the doctors in the state. I would like to clarify the process by which this occurs.

A basic policy of the Rhode Island Medical Society is that no one other than an officer of the Society may speak for the Society unless specifically authorized to do so. Such authorizations usually relate to the work of a specific committee. In those situations the chairperson of the committee or an alternate speaks to the media or in public. Generally, however, the president voices the position of the Society. The president (or other spokesperson) may not speak his or her personal views. If the president has views divergent from those of the Society, they may not be expressed publicly as the perception of the public is that the president is *always* speaking for the Society. In the event that the personal views of the president (or other spokesperson) are in such conflict with the view of the Society that he cannot in good faith support the Society's position, then that person cannot speak at all or must resign his office and speak out as an individual. This process insures that the official position of the Rhode Island Medical Society is always represented accurately.

It is essential that the Society operate according to a set of specific policies. This insures that the work of the Society will progress in a consistent and productive fashion and not be subject to the vagaries of an ever-changing leadership. The policies must be dynamic, however, and responsive to changing times. I perceive the job of the officers to be twofold. First, they must provide leadership in the formation of new policies. Second, they, with the assistance of staff, must carry out these policies to the best of their abilities.

The position of the Society on a specific issue is arrived at in an orderly and democratic fashion. All members may (and should) participate in this process. The basic policies of the Society must be approved by the House of Delegates. The House is comprised of representatives from all geographic areas, hospitals, and specialties. Although only official delegates may vote, any member may attend the meetings and speak. The House meets three times a year. Special sessions may be called if necessary.

The Council of the Society is composed of the officers and representatives from each county medical society. The Council meets six times yearly in alternate months. The Council makes decisions on policy matters using the previous decisions of the House as precedent and in accordance with the known objectives of the Society. All Council actions are presented to the House for approval. In the alternate months when the Council is not meeting, the Executive Committee, consisting of the officers, meets to carry on the business of the Society. All actions of the Executive Committee are sent to the Council for approval.

There are two categories of issues which require policy decisions. First are the broad issues of national concern. Examples include the malpractice crisis and the health hazards of smoking. On these issues, the Rhode Island Medical Society must rely on outside help to formulate specific policies and approaches. When I assumed the presidency last May, it became apparent that the Society had no stated policies in many of these areas. At my request the Council and subsequently the House approved the proposal that the Society adopt the policies of the AMA. The process by which the AMA decides its policies is similar to ours. The House of Delegates which meets twice a year approves all policy decisions. The AMA publishes its policies yearly and issues supplements as needed. The availability of a policy book has been of great help in replying to media questions in a consistent and intelligent manner. The policy book was distributed to the

Council and not one of the positions was questioned. In the event of disagreement, the policy can be reversed by the Society in the process described above. In actual fact, the policies of the AMA are well researched and have been of inestimable value to us. It is obviously impossible for a small society such as ours to duplicate this effort. If you have any questions about these policies, please call or write.

Second are issues of local interest only. In these areas, the decisions are made locally and we have constructed our own policy book. Such issues include our relationship with PRO, our decisions regarding impaired physicians, local peer review, and so forth. If you have questions about these policies, please call or write.

The medical society position on an issue thus represents the best collective view we can obtain of what is good for our patients and ourselves. As in any democratic organization, not everyone will be satisfied with every policy. If you are not satisfied, don't complain to your friends in the corridor. Complain to me or your representative to the Council. We shall be happy (even eager) to appoint you to a committee or task force so that your energy can be channeled into efforts to improve the policies of the Society.

In my role as spokesman for the Society, I have tried to express the policies of the Society. In one instance I called a special meeting of the council to clarify a controversial recommendation before speaking on it.

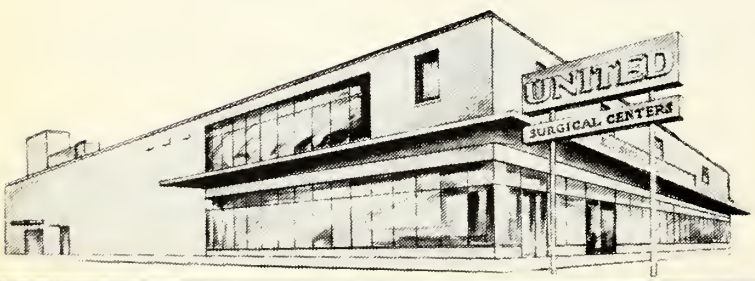
While the president is important in terms of leadership and the formulation of policies and perhaps critical in terms of his effectiveness in media relations, he remains the spokesperson for the Society's positions. His loyalty and allegiance to the positions of the Rhode Island Medical Society and the interest of the members must remain absolute. Personal views and loyalties to other organizations must be subordinate.

I think that the individual physician as well as the community of physicians is well represented by the Rhode Island Medical Society. The mechanism described above is the best guarantee that the representation is and will continue to be of high quality and in the best interests of all of us.

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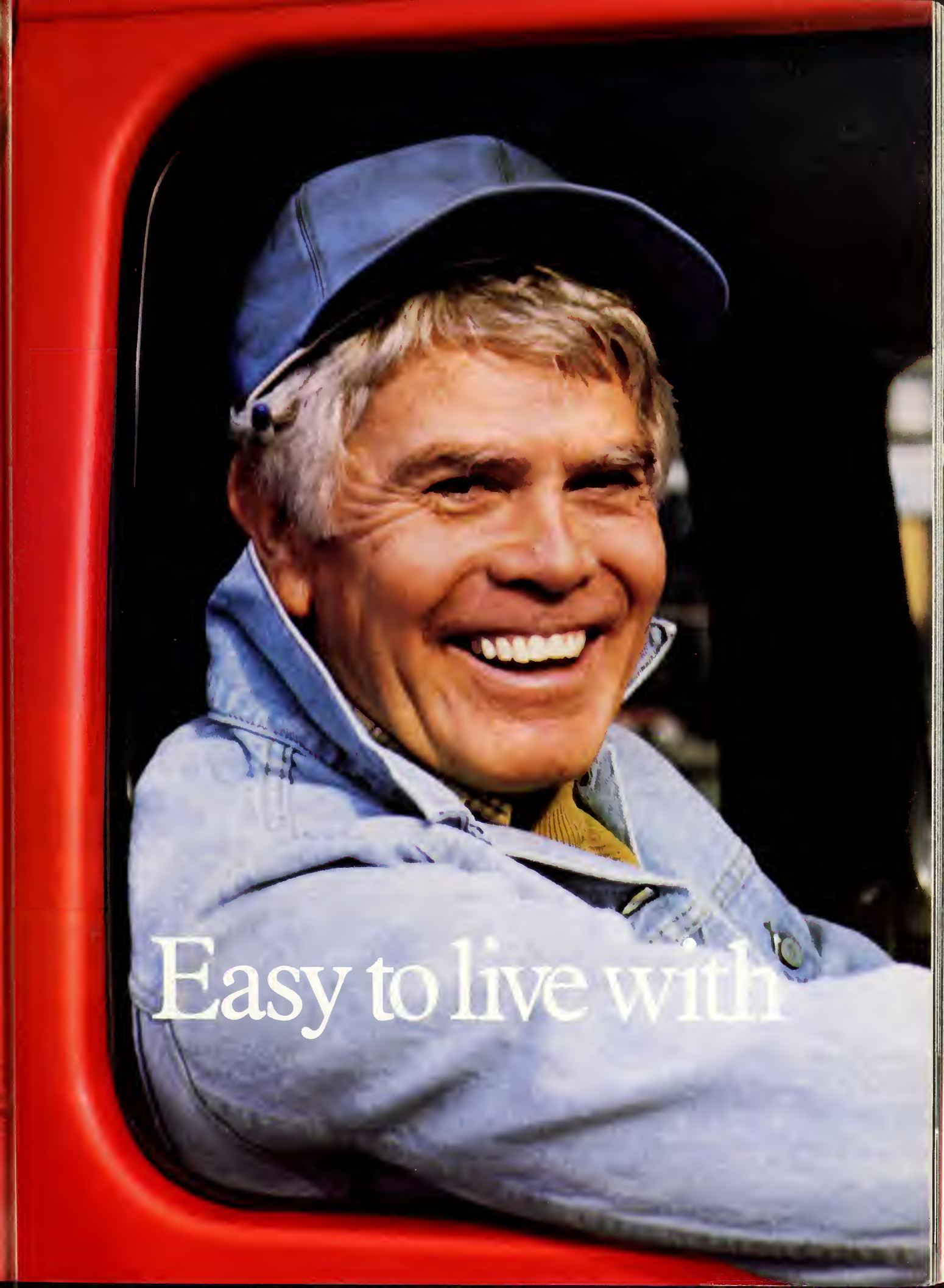
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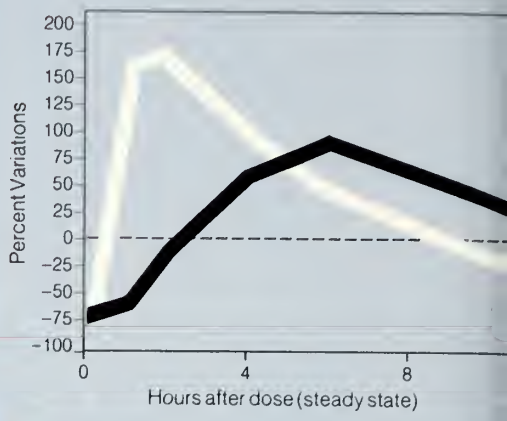
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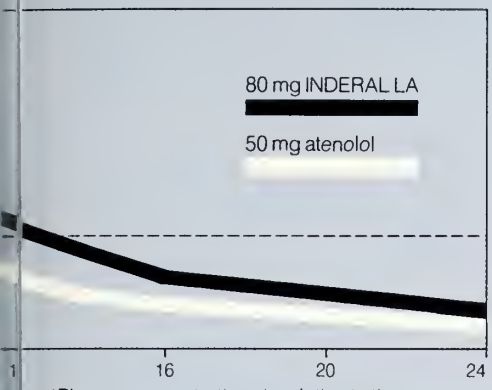
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CONTRAINDICATIONS

Propranolol hydrochloride (INDERAL® LA): Propranolol is contraindicated in: 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with propranolol.

Hydrochlorothiazide: Hydrochlorothiazide is contraindicated in patients with anuria or hypersensitivity to this or other sulfonamide-derived drugs.

WARNINGS

Propranolol hydrochloride (INDERAL® LA): CARDIAC FAILURE. Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow up in patients with a history of failure who are well compensated, and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or propranolol should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction following *abrupt* discontinuance of propranolol therapy. Therefore, when discontinuance of propranolol is planned the dosage should be gradually reduced and the patient carefully monitored. In addition, when propranolol is prescribed for angina pectoris, the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If propranolol therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute propranolol therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

THYROTOXICOSIS. Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

MAJOR SURGERY. The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

Nonallergic Bronchospasm (eg, chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD, IN GENERAL, NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution, since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

DIABETES AND HYPOGLYCEMIA. Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin. Hypoglycemic attacks may be accompanied by a precipitous elevation of blood pressure.

Hydrochlorothiazide: Thiazides should be used with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. In patients with impaired renal function, cumulative effects of the drug may develop.

Thiazides should also be used with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma.

Thiazides may add to or potentiate the action of other antihypertensive drugs. Potentiation occurs with ganglionic or peripheral adrenergic-blocking drugs.

Sensitivity reactions may occur in patients with a history of allergy or bronchial asthma.

The possibility of exacerbation or activation of systemic lupus erythematosus has been reported.

PRECAUTIONS

Propranolol hydrochloride (INDERAL® LA): GENERAL. Propranolol should be used with caution in patients with impaired hepatic or renal function. Propranolol is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that propranolol may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

CLINICAL LABORATORY TESTS. Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS. Patients receiving catecholamine-depleting drugs, such as reserpine should be closely observed if propranolol is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity, which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY. Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies, in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

PREGNANCY. Pregnancy Category C. Propranolol has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximal recommended human dose. There are no adequate and well-controlled studies in pregnant women. Propranolol should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

NURSING MOTHERS. Propranolol is excreted in human milk. Caution should be exercised when propranolol is administered to a nursing mother.

PEDIATRIC USE. Safety and effectiveness in children have not been established.

Hydrochlorothiazide: GENERAL. Periodic determination of serum electrolytes to detect possible electrolyte imbalance should be performed at appropriate intervals.

All patients receiving thiazide therapy should be observed for clinical signs of fluid or electrolyte imbalance, namely: Hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when the patient is vomiting excessively or receiving parenteral fluids. Medication such as digitalis may also influence serum electrolytes. Warning signs irrespective of cause are: Dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea and vomiting.

Hypokalemia may develop, especially with brisk diuresis, when severe cirrhosis is present, or during concomitant use of corticosteroids or ACTH.

Interference with adequate oral electrolyte intake will also contribute to hypokalemia. Hypokalemia can sensitize or exaggerate the response of the heart to the toxic effect of digitalis (eg, increased ventricular irritability). Hypokalemia may be avoided or treated by use of potassium supplements, such as foods with a high potassium content.

Any chloride deficit is generally mild and usually does not require specific treatment, except under extraordinary circumstances (as in liver or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction, rather than administration of salt, except in rare instances when the hyponatremia is life-threatening. In actual salt depletion, appropriate replacement is the therapy of choice.

Hyperuricemia may occur or frank gout may be precipitated in certain patients receiving thiazide therapy.

Insulin requirements in diabetic patients may be increased, decreased, or unchanged. Diabetes mellitus which has been latent may become manifest during thiazide administration.

If progressive renal impairment becomes evident, consider withholding or discontinuing diuretic therapy.

Thiazides may decrease serum PBI levels without signs of thyroid disturbance.

Calcium excretion is decreased by thiazides. Pathologic changes in the parathyroid gland with hypercalcemia and hypophosphatemia have been observed in a few patients on prolonged thiazide therapy. The common complications of hyperparathyroidism, such as renal lithiasis, bone resorption, and peptic ulceration, have not been seen. Thiazides should be discontinued before carrying out tests for parathyroid function.

DRUG INTERACTIONS. Thiazide drugs may increase the responsiveness to tubocurarine.

The antihypertensive effects of thiazides may be enhanced in the postsympathectomy patient. Thiazides may decrease arterial responsiveness to norepinephrine. This diminution is not sufficient to preclude effectiveness of the pressor agent for therapeutic use.

PREGNANCY. Pregnancy Category C. Thiazides cross the placental barrier and appear in cord blood. The use of thiazides in pregnancy requires that the anticipated benefit be weighed against possible hazards to the fetus. These hazards include fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult.

NURSING MOTHERS. Thiazides appear in human milk. If use of the drug is deemed essential, the patient should stop nursing.

PEDIATRIC USE. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Propranolol hydrochloride (INDERAL® LA): Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular. Bradycardia, congestive heart failure, intensification of AV block, hypotension, paresthesia of hands; thrombocytopenic purpura, arterial insufficiency, usually of the Raynaud type.

Central Nervous System. Lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances, hallucinations; an acute reversible syndrome characterized by disorientation for time and place; short term memory loss; emotional lability; slightly clouded sensorium; and decreased performance on neuropsychometrics.

Gastrointestinal. Nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation; mesenteric arterial thrombosis; ischemic colitis.

Allergic. Pharyngitis and agranulocytosis; erythematous rash, fever combined with aching and sore throat; laryngospasm and respiratory distress.

Respiratory. Bronchospasm.

Hematologic. Agranulocytosis; nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune. In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous. Alopecia; LE-like reactions, psoriasiform rashes; dry eyes; male impotence; and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes, and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

Hydrochlorothiazide:

Gastrointestinal. Anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation; jaundice (intrahepatic cholestatic jaundice), pancreatitis, sialadenitis.

Central Nervous System. Dizziness, vertigo, paresthesias, headache, xanthopsia.

Hematologic. Leukopenia, agranulocytosis, thrombocytopenia, aplastic anemia.

Cardiovascular. Orthostatic hypotension (may be aggravated by alcohol, barbiturates, or narcotics).

Hypersensitivity. Purpura, photosensitivity, rash, urticaria, necrotizing angiitis (vasculitis, cutaneous vasculitis), fever, respiratory distress, including pneumonitis; anaphylactic reactions.

Other. Hyperglycemia, glycosuria, hyperuricemia, muscle spasm; weakness; restlessness, transient blurred vision.

Whenever adverse reactions are moderate or severe, thiazide dosage should be reduced or therapy withdrawn.

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REFERENCES

1. Data on file, Ayerst Laboratories. **2.** Ravid M, Lang R, Jutrin I: The relative antihypertensive potency of propranolol, oxprenolol, atenolol, and metoprolol given once daily. *Arch Intern Med* 1985;145:1321-1323. **3.** Sumiye L, Vivian AS, Frisof KB, et al: Potassium loss associated with hydrochlorothiazide versus chlorthalidone. *Clin Ther* 1981;4:308-320. **4.** Ram CVS, Garreff BN, Kaplan NM: Moderate sodium restriction and various diuretics in the treatment of hypertension. *Arch Intern Med* 1981;141:1015-1019.

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Family Income and Mortality Rates: An Analysis of the National Mortality Survey

Disease-Specific Mortality Rates Were Inversely Proportional to Family Income

Eli Frenkel, PhD
Stanley M. Aronson, MD, MPH

An inverse relationship between economic status and mortality rate has been noted repeatedly.[1-10] Income, or economic status, it is argued, is a factor determining living standards, environmental conditions such as nutrition, housing and clothing, and access to advanced medical care, which collectively influence life expectancy.

Because some forms of disease appear to be more affected by conditions of living standards than others, a question necessarily arises as to whether this inverse relationship between income and mortality is constant for all forms of organic illness or only those which appear to be more sensitive to economic status and living standards. These same studies noted a decrease in the income differential in mortality rates when proceeding from middle to old age. Accordingly, a further question arises as to whether this age-related decrease in the income differential in mortality rates is similar in all groups of organic disorders or, if not, whether these additional differences are dependent upon economic status.

Materials and Methods

To answer these questions, the authors studied the national sample survey of deaths in the United States for 1966-1968.[11] The causes of death in this sample were grouped into three major diagnostic categories, each with unique pathophysiologic characteristics (see Table 1). Group A represents selected infectious and probably infectious diseases, including those of bacterial, viral, and parasitic etiology. Some entities, such as granulomatous disease and asthma, have been included since they carry a strong likelihood of infectious origin. Group B embraces identifiable forms of diffuse or localized disease of arteries, especially those with atherosclerotic alterations. Diabetes mellitus was included in this group because this metabolic disorder is a major risk factor for diffuse atherosclerosis. Group C-1 represents malignant neoplasms, the incidence rates of which are not known to be affected significantly by environmental conditions. Other malignant neoplasms which are said to have a degree of association with environmental influences (malignant neoplasms of buccal cavity, pharynx, respiratory system, and urinary tract origins) were placed in group C-2.

The data on deaths in Table 2 are derived from the National Mortality Survey (NMS), conducted and compiled by the Division of Vital Statistics, National Center for Health Statistics, for the years 1966-1968.[11] This national survey of 17,014 deaths in persons aged 25-84 years was obtained from a review of death certificates. The family income of the decedent was obtained by mail questionnaire directed to the person listed on the death record as the informant. Neither the underlying cause of death nor family income were independently verified by the authors of the survey.

Data from the death certificates were available from the entire sample. Data on family income obtained by questionnaire were incomplete. Responses on family income were received for ap-

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proximately 88 per cent of cases. Following its usual practice, the National Center for Health Statistics imputed values for all data which were missing, whether as a result of case non-response or item non-response.

The population base for calculating mortality rates which are used in this study (Table 3) were obtained from the current population survey conducted by the Bureau of the Census in March 1968.[13] Because the central dates for the two surveys used here are not identical, the rates computed are not accurate rates for the period covered. However, our interest is in comparing rates among groups and not in estimating levels of mortality. These comparisons should be affected only to a negligible degree by the eighth-month discrepancy between July 1967 (the central date for the NMS) and March 1968 (the central date for the current population survey). The current population survey does not cover institutional populations. Accordingly, deaths of this institutional population were similarly excluded from the National Mortality Survey.

The total sample size used here is 17,014 deaths. Deaths in the three groups of causes mentioned above represent 78.3 per cent of all the deaths in the National Mortality Survey. Group A represents 5.0 per cent of all deaths, group B 52.5 per cent, group C-1 15.6 per cent, and group C-2 5.2 per cent. Excluded from this analysis are the following diagnostic categories: motor vehicle and other accidents (3.9 per cent); suicide and homicide (1.5 per cent), senility and related disorders (1.5 per cent), cirrhosis of the liver (1.9 per cent), and all other miscellaneous and unspecified causes (12.9 per cent).

Age-specific mortality rates for each group are calculated by $D_a/P_a \times k$ where D_a = the number of deaths in age category a, P_a = population base for age category a, and k = 10,000. The income differential in mortality rates is measured by the ratio of the lowest income level (ie, under $3,000) mortality rate to highest income level (ie, $10,000 and over) mortality rate (INC_l/INC_h).

Table 1. — Selected Diseases

Group A: Selected infectious, parasitic, and granulomatous diseases:
Respiratory infections, non-tuberculous
- Asthma (241)
- Influenza (480-483)
- Pneumonia (490-493)
- Bronchitis (500-502)

Non-respiratory infections, non-tuberculous
- Septicemia and pyemia (053)
- Meningococcal infections (057)
- Infectious hepatitis (092)
- Meningitis, except meningococcal and tuberculous (340)
- Infections of kidney (600)

Chronic infections, tuberculous, parasitic, granulomatous
- Tuberculosis of respiratory system (001-008)
- Tuberculosis, other forms (010-019)
- Syphilis and its sequelae (020-029)
- Other infectious and parasitic diseases

Group B: Selected hypertensive, cardiovascular, and cerebrovascular diseases and diabetes mellitus:
Hypertensive, cardiovascular diseases
- Hypertensive heart disease (440-443)
- Other hypertensive disease (444-447)
- Arteriosclerotic heart disease including coronary disease (420)
- General arteriosclerosis (450)
- Other diseases of circulatory system (451-468)

Cerebrovascular disease
- Vascular lesions affecting central nervous system (330-334)

Diabetes mellitus (260)

Group C-1: Selected neoplasms:
- Malignant neoplasms of digestive organs and peritoneum (150-156.1, 157-159)
- Malignant neoplasms of breast (170)
- Malignant neoplasms of genital organs (171-179)
- Malignant neoplasms of other and unspecified sites (156.2, 165, 190-199)
- Lymphosarcoma and other neoplasms of lymphatic and hematopoietic tissues (200-203)

Group C-2: Selected neoplasms:
- Malignant neoplasms of buccal cavity and pharynx (140-148)
- Malignant neoplasms of respiratory system, not specified as secondary (160-164)
- Malignant neoplasms of urinary organs (180, 181)

Results

Tables 4-7 present age-specific and income-specific mortality rates and ratios for each of the three diagnostic groups as defined and described above.

Table 4 is limited to deaths caused by group A disorders (infectious diseases) per 10,000 population stratified by family income and age. The ratios of the mortality rates in families with incomes under $3,000 ($INC_l$) to families with incomes $10,000 or more ($INC_h$) are also included in the table.

The income differential in mortality rates in the younger ages is striking. The mortality rate associated with the lowest income category at age 35-44 years is 23 times higher than the mortality rate of the highest income category in this age range. The income differential (expressed as the ratio of INC_l to INC_h) declines with increasing age.

Table 2. — Deaths Stratified by Family Income and Age: National Mortality Survey Sample

Family Income	Age (years) 35-44	45-54	55-64	65-74	75-84	Total
Under $ 3,000	705	858	1,274	1,969	1,801	6,607 (38.8)*
$ 3,000-4,999	505	584	798	834	576	3,297 (19.4)
$ 5,000-6,999	522	586	660	392	295	2,455 (14.4)
$ 7,000-9,999	478	622	550	309	253	2,212 (13.0)
$10,000 & Over	459	653	647	373	311	2,443 (14.4)
Total	2,669 (15.7)	3,303 (19.4)	3,929 (23.1)	3,877 (22.8)	3,236 (19.0)	17,014 (100.0)

* numbers in parenthesis represent marginal percentage values.

Table 3. — US Population by Family Income and Age: 1968[13]

Family Income	Age (years) 35-44	45-54	55-64	65-74	75-84	Total
Under $ 3,000	1,724*	2,011	3,465	5,027	2,985	15,211 (18.8)
$ 3,000-4,999	2,120	2,301	2,813	2,488	835	10,556 (13.1)
$ 5,000-6,999	3,457	3,057	2,762	1,379	433	11,088 (13.7)
$ 7,000-9,999	6,224	5,095	3,494	1,286	461	16,560 (20.5)
$10,000 & Over	10,246	9,896	5,235	1,483	602	27,462 (34.0)
Total	23,771 (29.4)	22,361 (27.6)	17,769 (22.0)	11,662 (14.4)	5,316 (6.6)	80,878 (100.0)

* in thousands
† numbers in parentheses represent marginal percentage values.

Table 4. — Deaths Per 10,000 Caused by Group A Diseases, by Family Income and Age, and Ratios of INC_l to INC_h: US, 1966-68

Family Income	Age (years) 35-44	45-54	55-64	65-74	75-84
Under $3,000	9.2*	14.4*	14.9*	23.9	38.6
$3,000-9,999	1.7*	3.0*	6.2	13.9*	33.9*
$10,000 & Over	0.4*	1.0*	3.3*	16.5*	15.4*
INC_l/INC_h	23.00	14.40	4.52	1.45	2.51
P	<0.01	<0.01	<0.01	<0.01	<0.01

* Fewer than 100 deaths in the NMS sample.

Table 5 summarizes the mortality rates of individuals dying as a result of diseases assigned to group B. Diseases in this group constitute 52.5 per cent of all deaths in the sample. In each age category, the mortality rates are inversely related to the family income range. This range differential (INC_l/INC_h) is greatest in the youngest age group studied (35-44 years) and diminishes progressively as age increases.

Table 6 presents mortality rates for those individuals dying of neoplasms listed in category C-1, according to family income, age, and ratios of INC_l to INC_h. The inverse relationship between income and mortality rates exhibited in tables 4 and 5 is again apparent although the ratios are not as great; nor does this inverse relationship appear to prevail in the older age categories.

Table 7 represents mortality rates for the neoplasms in group C-2 by family income, age, and ratios of INC_l to INC_h. Patterns similar to those noted above are again observed. As in the case of tables 5 and 6, the inverse relationship between stated income and mortality rate diminishes beyond the age of 65 years and disappears beyond the age of 75 years.

Similar patterns are observed in each of the four tables above, grouped according to major causes of death: mortality rates increase progressively with increasing age; the mortality rates observed in each age category are inversely related to family income with this relationship most apparent in the youngest age group. The influence of family income upon these differential mortality rates diminishes progressively with increasing age. The influence of income differential upon mortality rate appears to be greatest in group A diseases and least in group C-1 diseases.

In tables 4 to 7, each vertical column of data was treated as a separate contingency table and a chi-square test was applied, with degrees of freedom equal to one fewer than the number of items in the column. When $p<0.01$, it was so indicated in each table; when $p \geq 0.01$, the abbreviation ns (not significant) was used.

Discussion

The tables indicate that when the mortality differential relating to income is high, as in the younger ages, the differential for those cause-specific categories of death which are believed to be the most affected by differences in standard of living (ie, infectious, parasitic, and granu-

Table 5. — Deaths Per 10,000 Caused by Group B Diseases, by Family Income and Age, and Ratios of INC_l to INC_h: US, 1966-68

Family Income	Age (years) 35-44	45-54	55-64	65-74	75-84
Under $3,000	30.9	76.6	129.3	209.2	426.5
$3,000-9,999	10.0	34.5	76.8	162.6	468.9
$10,000 & Over	3.5	12.3	47.9	128.8	337.1
INC_l/INC_h	8.83	6.23	2.70	1.62	1.27
P	<0.01	<0.01	<0.01	<0.01	n.s.

Table 6. — Deaths Per 10,000 Caused by Group C-1 Diseases, by Family Income and Age and Ratios of INC_l to INC_h: US, 1966-68

Family Income	Age (years) 35-44	45-54	55-64	65-74	75-84
Under $3,000	11.0*	25.4	39.6	63.5	78.3
$3,000-9,999	6.2	13.7	28.7	53.1	87.4
$10,000 & Over	2.5	7.4	15.9*	46.0*	75.0*
INC_l/INC_h	4.40	3.43	2.49	1.38	1.04
P	<0.01	<0.01	<0.01	<0.01	n.s.

* Fewer than 100 deaths in the NMS sample

Table 7. — Deaths Per 10,000 Caused by Group C-2 Diseases, By Family Income and Age and Ratios of INC_l to INC_h: US, 1966-68

Family Income	Age (years) 35-44	45-54	55-64	65-74	75-84
Under $3,000	3.3*	14.1	15.9	18.0	22.3
$3,000-9,999	1.1*	5.6	12.7	16.9	23.4
$10,000 and Over	0.7*	1.9*	6.9	15.7*	13.6*
INC_l/INC_h	4.71	7.42	2.30	1.15	1.64
P	<0.01	<0.01	<0.01	n.s.	n.s.

* Fewer than 100 deaths in the NMS sample.

Table 8. Ratios of Mortality Rates in Low Income Group (INC_l to High Income Group (INC_h) by Major Cause of Death and Age: US, 1966-68

Cause of Death	Percent of All Deaths	35-44	45-54	55-64	65-74	75-84
Total Population	100.0	9.17	6.34	3.00	1.55	1.30
Group A	5.0	23.00	14.40	4.52	1.45	2.51
Group B	52.5	8.83	6.23	2.70	1.62	1.27
Group C-1	15.6	4.40	3.43	2.49	1.38	1.04
Group C-2	5.2	4.71	7.42	2.30	1.15	1.64

lomatous disease) are substantially greater than the differential for causes of death, which at our current level of appreciation, seem to be less affected by standards of living (ie, group C-2 representing certain malignant neoplasms).

A higher income, in addition to improved environmental living conditions, generally provides greater access to tertiary type medical care; and the income differential for disorders in group B (ie, hypertensive, cardiovascular, and cerebrovascular disease as well as diabetes mellitus) which are probably less affected by socioeconomic factors than the causes in group A, but more effectively treatable by contemporary medical care than causes in groups C-1 and C-2, lies between these two groups. It is interesting that income differential ratios are higher for those neoplasms (Group C-2) which have been shown to bear an etiologic link with environmental factors (eg, lung disease) than for those neoplasms (Group C-1) which have not as yet been shown to be dependent upon some exogenous factor or factors.

For all diagnostic groups, the income differential in mortality diminishes with age and accordingly becomes increasingly insensitive to the influence of income. The decrease of income differential (as measured by the ratio INC_l to INC_h) signifies, therefore, that younger adults are more selectively vulnerable to diseases which are more related to living conditions than are older persons. Such findings suggest that some selective factors are operative: The magnitudes of vulnerability are obviously greatest in the youngest age groups where biologic heterogeneity is most marked. As selective attrition operates with increasing age, the biologic differences in vulnerability will necessarily be diminished by virtue of this process of selection and the residual, elderly population will be somewhat more homogeneous. Moreover, the socioeconomic factors which may influence mortality in youth are clearly less influential upon the essentially sedentary sheltered existences of the senior years. Both factors (non-random mortality selection in the middle decades of life and sheltered existence in the elderly decades) may serve to neutralize any substantial influence exerted by family income upon mortality rates in the older years of life.

Finally, it should be emphasized that these retrospective data (deaths occurring in 1966-1968)

reflect access to and quality of health care rendered prior to the establishment of Medicaid and Medicare, social programs which reduced many of the income-generated inequities of general medical care. It would be interesting to study more recent death samples to determine whether the income-related patterns described in this paper have diminished.

Summary

The National Mortality Survey of 17,014 deaths in the United States for 1966-1968 was studied to determine the existence and character of relationships between family income and mortality rates. Selected causes of death were assigned to three major diagnostic categories: infectious diseases, cardiovascular and cerebrovascular diseases; and certain neoplastic diseases. In general, the disease-specific mortality rates were inversely proportional to the stated family income. In each diagnostic category the income differential was most evident in the youngest age groups, progressively diminishing to a nonsignificant difference beyond the age of 75 years. Within this sample, the sensitivity of mortality rates to family income was most apparent in those deaths caused by infectious disease and least apparent in those dying of neoplastic disease.

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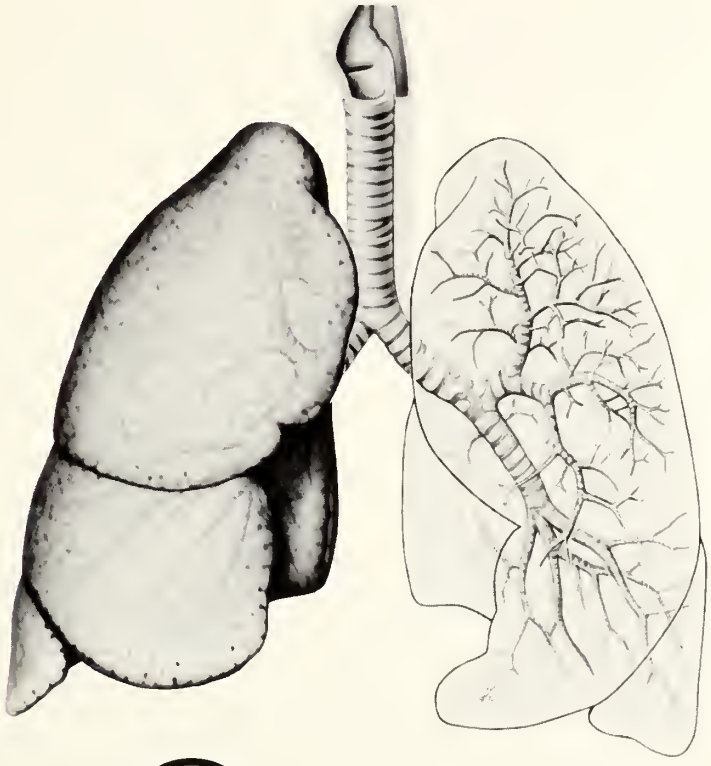
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Brief Summary Consult the package literature for prescribing information

Indications and Usage: Ceclor* (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae* and *S. pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out

Precautions: *General Precautions* — If an allergic reaction to Ceclor* (cefaclor, Lilly) occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest*

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis

Usage in Pregnancy — *Pregnancy Category B* — Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor* (cefaclor, Lilly). There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed

Nursing Mothers — Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Ceclor is administered to a nursing woman

Usage in Children — Safety and effectiveness of this product for use in infants less than one month of age have not been established

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are uncommon and are listed below

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70)

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients)

Causal Relationship Uncertain — Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician

Hepatic — Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40)

Hematopoietic — Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40)

Renal — Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200)

[0617B2R]

Note: Ceclor* (cefaclor, Lilly) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information

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SPECIAL REPORT

Hospital-Medical Staff Joint Ventures: Current Concepts

Hospital-medical staff joint ventures are viewed as a method of keeping patients from being lost to another health plan or as a means of facilitating participation in other health plans on a stronger, more competitive basis. In addition, these joint ventures are intended to provide investment opportunities and tax shelters for both physicians and hospitals.

Except for anecdotal information and a few case studies, there are very few data available on the nature and extent of hospital-medical staff joint ventures. A 1984 survey conducted by the American Hospital Association (AHA) suggests that these joint ventures are still very much the exception rather than the rule. Less than 12 per cent of the hospital respondents were involved in any of the ten most common hospital-physician joint ventures in January 1984. These were preferred provider arrangements (PPOs) (4 per cent) and medical office buildings (3.3 per cent). The other types of joint ventures mentioned in the survey were health maintenance organizations (2.2 per cent), primary or ambulatory care centers (2.2 per cent), independent practice associations (2.1 per cent), freestanding minor emergency centers (1.5 per cent), freestanding imaging centers (1.1 per cent), ambulatory surgical centers (0.9 per cent), freestanding laboratories (0.8 per cent), and home health agencies (0.5 per cent). The survey did not cover a number of less prevalent joint venture activities, such as birthing centers, women's health centers, eyeglass dispensaries, and answering services.

The majority of joint venture activities reported in the survey were located in four geographic areas: the Pacific states (18.72 per cent), the mountain states (15.02 per cent), New England (17.26 per cent), and the east north central states (16.94 per cent). However, the popularity of various types of joint ventures differs among these regions. In the Pacific and mountain states, preferred provider organizations were most common; in New England, HMOs and IPAs were most prevalent; and in the east north central states, PPOs and medical buildings were equally popular.

The surveyors cautioned that their data are undoubtedly an understatement of the current number of operational joint ventures, since the survey is based on joint ventures in existence as of January 1984. Nevertheless, they pointed out that even if the number of these activities has doubled since January 1984, the number of hospital-medical staff joint ventures would be only approximately 1,200.

The survey predicts that it is likely that large, nongovernmental, nonteaching hospitals in large urban areas, especially in the four geographic areas discussed above, will continue to develop joint ventures. The changing financing environment and the increasing supply of physicians suggest that the number of hospital-medical staff joint ventures will increase in those parts of the country where the competition for patients is greatest.

Types of Joint Ventures

There are great variations in the structure of hospital-medical staff joint ventures, depending on the various needs and opportunities in each locality. In fact, the distinguishing feature of these joint ventures is their diversity. The hospital may participate in the joint venture directly, through a for-profit or nonprofit subsidiary, a parent corporation, or a separate subsidiary of the parent. The physician participants may decide to form a partnership or incorporate or they may individually sign one joint venture agreement with the hospital.

This paper is adapted from a report of the Board of Trustees, American Medical Association, Interim Meeting, December 8-11, 1985, Washington, DC.

The hospital and the physician group then establish their joint venture organization, a jointly-owned structure which may be a corporation; a general partnership, in which the hospital and the physicians share profits and losses equally and have equal rights concerning management decisions; or a limited partnership, in which the limited partners do not participate in the control of the business. Generally, the type of structure chosen depends on the type of activity being planned. The joint venture may develop all of these structures if the participants intend to undertake more than one business venture and these ventures require different investment vehicles. Another joint venture structural arrangement would establish a central organization, usually a for-profit or nonprofit corporation, and then establishes subentities in the appropriate structures as needed. In all of these arrangements there may be variations in the percentage of the entity that either party owns.

Legal Considerations

The antitrust issues faced by various forms of hospital-physician joint ventures include price-fixing liability, degree of market power, and the foreclosure of actual or potential competition. Before resigning as Assistant Attorney General in charge of the Antitrust Division of the US Department of Justice in April 1985, J. Paul McGrath announced that the Justice Department would release its first detailed analysis of antitrust aspects of provider-sponsored and other PPO joint ventures. Although formal detailed guidelines have yet to appear, McGrath outlined a number of basic considerations of importance to the Justice Department in a series of speeches he delivered before leaving office.

In these speeches, McGrath said that PPOs controlled by insurance companies, third-party administrators, or independent contractors have "real pro-competitive potential and pose little risk of anti-competitive harm." PPOs controlled by providers present somewhat more of an antitrust risk and therefore are subject to greater scrutiny, but his agency recognized that provider PPOs "generally provide significant competitive benefits."

According to McGrath, the Antitrust Division's general approach to analyzing provider controlled PPOs used principles similar to those applicable to joint ventures generally. He stated that at a minimum, a joint venture among competitors must satisfy three elements to survive antitrust scrutiny: (1) the agreements among physicians setting price and utilization standards must be reasonably related and ancillary to a cooperative activity that promotes competition; (2) the market share of the joint venture must not be large enough to foreclose effective competition; and (3) the parties must have no anticompetitive purpose. To meet the first element, ie, that agreements among competitors are reasonably related and ancillary to the new joint venture, the provider-controlled PPO should be able to show that it offers economic integration and efficiencies that outweigh the potential harm from lessening competition among providers. McGrath elaborated by stating that although providers typically do not share risks, some aspects of PPO agreements that would work in favor of a conclusion that an efficiency-enhancing integration is present include: an agreement to treat patients on a fee-for-service basis at reduced or discounted levels or pursuant to some fee schedule with no balance billing; an agreement to abide by some limitation of the practices of the physicians in the form of utilization review; an agreement to administer claims and jointly market their venture; and an agreement to select a group of limited size to engage in bidding for contracts against other panels.

The second element of the antitrust scrutiny concerns the PPO's market share. McGrath stated that the Antitrust Division was unlikely to challenge a provider-sponsored PPO with fewer than 20 per cent of the physicians in private practice in the particular market. Moreover, he stated that provider-sponsored PPOs with more than 20 per cent of the market would not automatically fail antitrust muster but would be subject to a market-specific analysis to assess the PPO's likely competitive effects in its market. From an antitrust perspective, McGrath said, PPOs need not be overly concerned about excluding physicians and hospitals as participants. "The essential feature of a PPO is its selectivity, and the primary competitive risks associated with PPO formation . . . are with overinclusiveness rather than exclusion."

Third, the Antitrust Division would look closely at evidence of anticompetitive intent and at collateral arrangements that bear no relationship to the PPO's success and that pose a competitive problem. According to McGrath, any attempt to influence the PPO will raise antitrust questions. Efforts to prevent physicians and hospitals from associating with other health care plans or to discourage them from granting similar or greater

price concessions to other PPOs also will be carefully examined. "In short, consistent with conventional analysis of ancillary restraints, the PPO agreement must be no broader than necessary to promote the legitimate purposes of the venture."

Further Antitrust Considerations

In a related development, the Attorney General of Wisconsin recently released an opinion regarding health care providers' joint ventures under the Wisconsin and US antitrust laws. The Attorney General stated that health care providers can best insulate themselves from antitrust liability by jointly cooperating through the use of a truly independent intermediary. He thought that antitrust exposure could be "virtually eliminated" through the use of an independent intermediary if certain conditions were met, including the following: (1) the intermediary dealt individually with each provider; (2) the individual provider-intermediary agreements were nonexclusive; (3) the market share for the provider's groups services involved in the intermediary's plan was limited to a moderate share of the relevant market; (4) the intermediary was used only for a particular contract or contracts and not for all of the contracting of the chosen providers; (5) the cooperating providers did not agree among themselves on prices and other terms they would be willing to offer to the intermediary; and (6) the providers involved would not pressure the intermediary to limit participation in the intermediary's plans to particular members of the provider group. The provider group members could approach potential intermediaries and indicate their desire to participate in such an intermediary-sponsored plan without significant antitrust exposure provided they do not agree on the prices and other terms they would accept from the intermediary and provided they do not compromise the intermediary's independence by such overtures.

According to the Wisconsin Attorney General, a joint venture of health care providers which does not use an independent intermediary involves greater antitrust exposure. What may save this arrangement from being deemed a *per se* violation of the antitrust laws is the fact that the price setting function may be ancillary or necessary to the creation of a new competitive entity. "However," he adds, "where the colluding providers are already viable competitors in the specific market for which the new joint venture is created, it is doubtful that such joint action could be taken out of the *per se* category." The price setting would appear to be simply a naked restraint of trade and not ancillary to any new procompetitive venture. Where providers cannot individually compete and where providers create a new competitive entity no larger than necessary to enter a given health care market, the joint action would most likely not be declared *per se* illegal but would be analyzed under the rule of reason. In other words, the burden would be on the provider group to demonstrate that they could not successfully compete individually in the specific markets at issue. These standards appear to be more onerous than the guidelines articulated by McGrath.

Antifraud and Abuse Statutes

In addition to the antitrust problems facing joint ventures, the Medicare and Medicaid antifraud and abuse statutes prohibit the knowing and willful solicitation, receipt, offer or payment of any remuneration in return for the referral of patients or customers or the generation of business for the party furnishing remuneration. Such remuneration includes kickbacks, bribes, and rebates given or accepted in cash or in kind, directly or indirectly, and overtly or covertly. The statutory language indicates the intent of Congress is to include practices that the federal government believed were causing unnecessary utilization and costing billions of dollars in unnecessary and fraudulent claims.

If broadly construed, the antifraud and abuse statutes would prohibit certain types of common joint venture activities. Many hospital-physician joint ventures incorporate "risk-sharing" or "incentive" features under which the hospital rewards attending physicians whose care of patients results in hospital costs that fall short of the applicable DRG amount under the Medicare prospective payment system. In these arrangements, the hospital usually pays a percentage of its excess DRG payment to the attending physician directly, or credits the amount to a special account maintained on behalf of the physician group that is its partner in the joint venture. Inasmuch as such payments may be viewed as remuneration for the referral or admission of patients by physicians participating in the joint venture, they constitute potential violations of the Medicare and Medicaid statutes.

Other types of hospital-physician joint venture arrangements involve the creation of corporations or partnerships to finance and operate health care facilities or equipment. Frequently

such joint ventures are dependent upon hospital contributions in the form of capital, loan guarantees, hospital-owned land, management services, financial and data services, billing and collection services, or ancillary health care services. The physicians' receipt of such benefits from the hospital, if related to the pattern of referrals, may constitute prohibited forms of "remuneration" under the Medicare and Medicaid laws. Facility or equipment lease transactions in which payments are related to the number of patients a physician refers to the contracting hospital, or the number or value of services provided to patients may be held to violate the antifraud and abuse statutes.

A number of decisions indicates that the Department of Health and Human Services (DHHS) and the courts interpret these statutes broadly. The most recent decision, *United States v Greber*, concerned a cardiologist whose company, Cardio-Med, Inc, provided physicians with diagnostic services. At issue in this case was the Holter-monitor service provided. Cardio-Med billed Medicare for the monitor service and forwarded a portion (40 per cent but not to exceed $65.00 per patient) of the payment received to the referring physician. The fees were described as payment to the referring physician for explaining the results to the patients. There was evidence that the referring physicians received their payments even though Greber actually evaluated the Holter-monitor results. The court found that, according to the language and purpose of the statute, if the payments to the referring physicians were intended to induce those physicians to use Cardio-Med's services, the statute was violated, even if the payments were also intended to compensate for professional services.

Greber and earlier decisions reflect an inclination by the courts to accept DHHS's determinations that specific financial arrangements violate the illegal remuneration laws. According to one expert, the following guidelines may be helpful:

(1) DHHS and the courts will look beyond the form of the relationship to its substance.
(2) A violation occurs when any remuneration, whether it is called a bribe, kickback, or rebate, is offered or solicited, given or received in exchange for the referral of patients or the generation of business — even if the payment is a reasonable return for the service provided.
(3) DHHS has instructed its carriers to detect and report to the Office of the Inspector General all cases involving payments to persons who are in a position to refer patients or to generate business for the person making the payment.
(4) When the parties' intent has to be implied from the surrounding facts, the following points are frequently considered: (a) whether the practice has a tendency to encourage unnecessary utilization; (b) whether the practice causes either increased costs or has the potential of increasing costs to the government; and (c) whether the amount of remuneration is related to the number of referrals, the dollar amount of the business generated, or a previously agreed-to amount which does not vary according to fluctuations in referrals or business.
(5) Whether there are legitimate business reasons for the payment, and the payment is a reasonable value for the goods, facilities, or services provided, and such goods, facilities, or services are reasonably necessary.

Each joint venture must be structured to avoid these problem areas or at least to minimize the risk. Physicians contemplating participation in a joint venture should obtain knowledgeable legal counsel to analyze the particular details of the arrangement and to structure the business relationships to comply with these laws.

Conclusion

At this time, there is a great deal of interest in hospital-medical staff joint ventures, but relatively few are in operation as yet. Those that are operational are relatively new and structurally varied, so that there is little significant experience to evaluate. The legal and regulatory climate for hospital-physician joint ventures is quite turbulent at the present time, and there is no expectation of more consistent policies in the immediate future. Physicians contemplating participation in these joint ventures should obtain the advice of legal counsel and financial advisers before taking action in order to minimize the risks of antitrust liability and violation of the Medicare and Medicaid fraud and abuse statutes, and also to evaluate all other legal and financial issues. Physicians should appraise the benefits and risks of each joint venture opportunity in light of their individual circumstances. ■

The Medical Malpractice Crisis

The Insurance Liability Crisis Pervades All Segments of Our Population

Charles E. Millard, MD
Wendy J. Smith

In recent years the possibility of a malpractice suit has haunted many physicians throughout the country. Increasingly, the physician is acutely aware of the potential for legal liability each time he or she treats a patient. This fear is well founded. The number of claims and suits against physicians and hospitals has mushroomed. Settlements and awards have broken all records with million-dollar payouts becoming increasingly common. As a result, physicians' costs for professional liability insurance have risen to extraordinary levels in some areas, threatening to divert some physicians from their major specialties and barring young physicians from practicing in specialties or places in which premiums are especially high. Today's professional liability climate threatens to restrict patients' access to quality medical care.

Together with the multiplying claims and rising premiums, there is a growing awareness that many physicians are resorting to the practice of "defensive medicine" — ordering additional tests and procedures in diagnosis and treatment — to protect against charges of omission and to justify their actions should any claims later be filed. This concern was heightened in Rhode Island when the Supreme Court ruled in the 1982 decision *Wilkinson v Vesey* that "if a physician, as an aid to diagnosis, does not avail himself of all the scientific means available to him, he can be considered to be negligent." While the decision was modified five years later to require physicians to perform all reasonable tests and procedures *(Schenck v Roger Williams General Hospital),* the issue of defensive medicine remains very real for most Rhode Island physicians. It has been estimated that defensive medicine may add anywhere from $15 billion to $40 billion annually to health care costs nationally. These costs are largely borne by society as a whole at a time when there is nationwide pressure to reduce health care costs.

Reprinted by permission, *Rhode Island Bar Journal,* April 1986

Charles E. Millard, MD, is the founder of the Bristol County Medical Center and past president of the Rhode Island Medical Society (1982-1983) and the Rhode Island Chapter, American Academy of Family Physicians (1950-1951 and 1982-1983).

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Historical Developments

Professional liability suits did not begin to materialize in significant numbers until the 1930s — a development that paralleled the birth of modern medicine and its sophisticated technology. There was an increase in the number of claims until World War II and then a temporary decline.

After World War II, the problem surfaced again, increasing in the late 1960s and early 1970s. The federal Commission on Medical Malpractice in 1973 attributed the growing number of claims to several factors. First, many more people during the post-war period were able to afford health care, automatically increasing the exposure to incidents that could lead to suits. At the same time, the health care system had become much more complex as the result of medical innovations. Some of the new diagnostic and therapeutic procedures were associated with new risks of injury; as drugs became more potent, hazards increased. The Commission's findings concerning the growth of claims and awards merely underscored a trend. "Between 1935 and 1975 — in that 40-year period — 80 per cent of all medical malpractice suits were filed in the final five years of that period," Elvoy Raines, a lawyer with the American Society of Law and Medicine told the

Senate Committee on Labor and Human Resources on July 10, 1984.

As the wave of claims began to mount in the early 1970s, some professional liability carriers began to reconsider their involvement in what had become a highly volatile line of business. In New York, for example, Employers Insurance of Wausau, Wisconsin, which had underwritten the medical society's professional liability program for 25 years, pulled out of this market in 1973. New York physicians, scrambling for another carrier, engaged Argonaut Insurance Company to provide the coverage. Argonaut agreed but increased the rates 93.5 per cent. Late in 1974 Argonaut requested another 200 per cent increase and shortly thereafter withdrew from the market altogether. The St. Paul Companies, which in 1975 wrote professional liability insurance for 48,000 physicians in 48 states, started to withdraw from the market after estimating the potential claims at 5,000 in 1975 — a 225 per cent increase over the 1,538 claims filled against the company in 1970. The carriers were unprepared for such massive litigation and many were driven out of the medical malpractice market. For physicians in many states, including Rhode Island, there was a sudden "crisis of availability" when it became impossible to purchase insurance coverage at any price.

The Crisis of the 1970s

Two major developments took place in the mid-1970s. First, physicians in many states mounted campaigns to enact legislation to ease the crushing liability burden — shortened statutes of limitation, ceilings on amounts of awards, limits on lawyers' contingency fees, arbitration, prescreening panels, tightened medical discipline, and others. In Rhode Island, the following changes in the tort system were enacted during 1975 and 1976:

Ad damnum: Before 1975, plaintiffs could sue for a specific dollar amount of damages. This provision was eliminated, and judges and juries now are responsible for awarding damages.

Informed consent: The 1976 malpractice law revisions changed the doctrine of informed consent to a preliminary question of fact by the court rather than the jury.

Res ipsa loquitur: Also changed in 1976 was the doctrine of *res ipsa loquitur* to a preliminary question of fact by the court rather than the jury.

Collateral source rule: This was changed to permit but not mandate disclosure of other sources to prevent duplicate payment for damages.

Statute of limitations: In 1975, the statute of limitations was changed to two years from the incident, discovery, or both, and to 18 years of age for minors. This later was modified to three years.

Screening panels: The intent of screening panels was to eliminate frivolous suits. Originally, the screening panels included two attorneys and one physician. Either the defendant or plaintiff could refuse to accept the findings of the panel and proceed to a jury trial. In an attempt to "streamline" the panels, the General Assembly passed an amendment in 1982 changing the composition of the panel to a single judge. The ruling of the judge was absolute and not subject to appeal or jury trial. The Rhode Island Supreme Court in April 1983 found the panels to be unconstitutional, thereby eliminating them from the system.

Measures to increase control over the quality of medical care were enacted through establishment of the Board of Medical Review, which was funded by an assessment of Rhode Island physicians and hospitals, and a continuing medical education requirement for relicensure on a triennial basis. Both of these remain in effect today.

Second, the crisis of the mid-1970s spawned alternative forms of coverage. In a few states, physicians, frustrated by huge premiums charged by commercial carriers and resistant to restricted insurance policies, created physician-owned nonprofit companies to provide professional liability protection. By the end of 1977 there were 15 medical society created physician-owned companies functioning in the nation, covering some 76,000 physicians, and five others were in the planning stages. That count did not include several other physician-owned companies and programs, such as the California-based Doctors' Company, which had no direct ties to medical societies.

Some legislatures, including the Rhode Island General Assembly, created joint underwriting associations to provide professional liability protection to physicians and hospitals in states in which the market had evaporated. Effective June 16, 1975, the Department of Business Regulation adopted Emergency Regulation XXI which established the Medical Malpractice Joint Underwriting Association of Rhode Island (JUA). The General Assembly later approved legislation which authorized the Department to promulgate regulations relating to medical malpractice in-

surance and validating Emergency Regulation XX1. The intent of these two actions was to provide a continuing stable source of medical malpractice insurance and incidental coverage for all providers of health care in Rhode Island.

The Crisis of the 1980s

Despite the tort reforms enacted in the mid-1970s and the insurance protection offered by the JUA, the malpractice crisis has continued to burgeon. Between 1980 and 1985, the JUA requested a total of 588 per cent in malpractice premium increases from the Department of Business Regulation. Only 139 per cent in rate hikes were granted, leaving the JUA with a $100 million deficit. In 1976, the JUA paid $400,000 in settlements compared to $11,492,000 in 1984. The number of indemnity claims escalated from one in 1976 to 145 in 1984. And the average loss per claim rose from $4,000 in 1976 to $79,000 in 1984.

To American physicians in general and some specialists in particular, it was becoming increasingly clear that a new "crisis" was developing as insurance premiums rose to new levels. In May 1982, Doctor Ivan Neubauer, then chairman of the board of NORCAL Mutual Insurance Company, San Francisco, described the situation from the physician's point of view: "We are facing a 'crisis of affordability.' We need adequate rates of coverage and sometimes are forced to collect obscene premiums that continue to climb. There doesn't seem to be any relief in sight." When the National Association of Insurance Commissioners analyzed claims for the year beginning July 1, 1985 through June 30, 1986 — a "crisis" year — there were a total of 14,074 claims against physicians and surgeons. By 1983, the total number of claims against these professionals rose to more than 40,000.

The Costs of the Malpractice Crisis

Since June 1982, the American Medical Association Committee on Professional Liability has been conducting an in-depth continuing study of the direct and indirect costs of professional liability. The committee predicted that in 1982 premiums paid for protection against professional liability would range from $1.43 billion to $1.47 billion. By 1983, the committee estimated, these premiums would range from $1.645 billion to $1.75 billion. This is just the price of purchasing insurance protection and does not include the costs of the resolution of claims by the courts nor many other hidden costs.

Among these costs is the price tag associated with "defensive medicine," estimated by the AMA to be some $15.1 billion annually. These calculations were made after reviewing an earlier AMA study indicating that 40 per cent of responding physicians reported that they prescribed additional diagnostic tests and 27.2 per cent that they provided additional treatment procedures in response to the increased risk of malpractice suits. Other surveys have estimated that defensive medicine constitutes 25 to 50 per cent of the cost of treatment. The problem was further exacerbated for Rhode Island doctors after the 1972 Supreme Court decision previously noted although this was later modified.

The committee further calculated that physicians who had claims filed against them in the past five years spent a total of 3.7 days in depositions and court appearances taking them away from their practices. "The projected total income loss here could be estimated to range from $10 million to $44.7 million," the committee pointed out.

The greatest cost of the crisis is not one that can be calculated in dollars, but is reflected in the emotional toll on physicians. Nearly 28 per cent of the respondents in a recent Rhode Island Medical Society survey indicated that they planned to retire early as a result of the malpractice crisis. An additional 15 per cent planned to curtail their specialty practices and nine per cent would seek employment where malpractice coverage is offered as a fringe benefit. Four per cent reported they would leave Rhode Island while three per cent planned to practice without insurance. The survey, which generated more than 700 replies, was taken in response to a request from the Legislative Commission on Medical Malpractice.

Particularly disturbing are the figures concerning early retirement. Approximately 39 per cent of the 1,821 physicians actively practicing medicine as of December 31, 1983 were 55 years or older. The retirement of a significant portion of this group would be serious at a time when the rate of growth of the physician population in Rhode Island is the lowest of all 50 states. During the period 1980-1983, the rate of growth was 5.7 per cent in contrast to 10.8 per cent in Massachusetts, 12 per cent in Maine, 10.5 per cent in Connecticut, 14.6 per cent in New Hampshire, and 9.8 per cent in Vermont. Moreover, Rhode Island has 222 physicians/100,000 population while the New England average is 287/100,000.

Federal Moves Toward Reform

While the federal government traditionally has delegated the responsibility for insurance-related issues to state legislatures and local courts, there are positive indications that this "hands-off" approach to malpractice may change in the near future because of the cost impact on federal programs such as Medicare and Medicaid. Senator Orrin Hatch (R., Utah) has introduced a professional liability bill which would provide federal incentives for states to adopt malpractice reform. Senator Claiborne Pell is a co-sponsor. Under the bill, a state would be eligible to receive federal grants if the following reforms are adopted by the state and applied to cases involving health care malpractice:

- Mandatory periodic payments for awards of future damages greater than $100,000
- Reduction of awards by the amount of compensation received from other sources
- Limitation of awards of non-economic damages to $250,000
- Limitation of attorneys' contingency fees to 10 per cent of any awards in excess of $200,000

The bill also requires expanded peer review activities by state medical societies, active risk management programs by hospitals and insurance companies, and closer liaison between malpractice carriers and state disciplinary agencies. Moreover, licensing fees from health care professionals would be allocated to state disciplinary agencies.

An altogether different approach has been proposed by legal expert Jeffrey O'Connell, known for his development of the "no-fault" automobile insurance concept. While the no-fault approach is most appropriate for industrial or automobile accidents where a clearly definable mishap has occurred, O'Connell contends that it can be extended to other liability cases. The Medical Offer and Recovery Act, introduced by US Representatives Henson Moore (R., Louisiana) and Richard Gephardt (D., Missouri), would encourage a health care provider to offer a settlement within six months of the alleged incident. The settlement would cover payment for such "net economic losses" as out-of-pocket expenses, including the costs of medical care, lost wages, rehabilitation expenses, and reasonable legal fees. Once the offer had been made, the patient would lose all rights to judicial review except possibly to dispute the amount of economic loss as it accrues. There would be no provision for punitive damages or awards for "pain and suffering."

If no settlement offer is made, the case would be adjudicated under the current tort system. The patient would have full access to the courts and could seek non-economic damages in addition to an award for economic losses. While an earlier version of the bill transferred the burden of proof to the defendant, the current proposal leaves it with the plaintiff.

The bill gives individual states the option of passing such a law. But in those states which had not acted by January 1, 1988, the federal bill would apply to patient care paid for by the federal government. These patients include Medicare beneficiaries, military personnel, veterans, and federal employees.

Reform on the State Level

Two Rhode Island groups have held an intensive series of meetings to address the professional liability crisis on the state level. The Legislative Commission on Medical Malpractice heard testimony from physicians, attorneys, the Joint Underwriting Association, the Board of Medical Review, legal expert Jeffrey O'Connell, consumer advocate Ralph Nader, and hospitals. More than 300 people attended an open hearing of the Commission on February 5, 1986. The 18-member Commission, which issued its report to the General Assembly earlier this spring, includes eight attorneys, six of whom are plaintiff's attorneys; one judge; three physicians; one insurance claims manager; one hospital association executive; one housewife; one retardation center executive; and two college professors. It was appointed by the General Assembly in 1984 in lieu of acting on a five-part malpractice reform package introduced by the Rhode Island Medical Society.

Meanwhile, under the aegis of the Hospital Association of Rhode Island (HARI), a group of 17 organizations in Rhode Island met weekly throughout the fall and winter to get a handle on the crisis. Included in the Rhode Island Medical Liability Coalition were representatives of the Rhode Island Medical Society, HARI, Aetna Life & Casualty, St. Paul Fire & Marine Insurance Co., Rhode Island Business Group on Health, AFL-CIO, Rhode Island Federation of Chambers of Commerce, Ocean State Physicians' Health Plan, Rhode Island Group Health Association, JUA, Blue Cross & Blue Shield, Starkweather & Shepley Insurance Co., and the Rhode Island Society of Hospital Risk Managers, among others. Meetings were held with physicians, attor-

neys, hospitals, insurers, and officials from the Governor's office and Department of Business Regulation. The Coalition has endorsed several reform proposals, including a $250,000 cap on awards for pain and suffering, reduction of the rate and effective date for interest payments on awards, and a limitation on attorneys' contingency fees.

As of this writing, it is not clear what action, if any, the General Assembly will take on the two sets of proposals.

Conclusion

The medical professional liability crisis is a serious one, affecting physicians, hospitals, and patients and the delivery and cost of medical care. Any legislative and judicial reform should: (1) assure fair and adequate compensation for injuries arising from medical negligence; (2) resolve professional liability claims speedily and efficiently; (3) recognize the unusual vulnerability of physicians; and (4) provide a reasonable degree of protection from frivolous suits so that access to care and the costs of care are not adversely affected. The purpose of these reforms is not to protect physicians and reduce their insurance premiums. Rather it is to cut the waste and unfairness of a legal system that has become outrageously expensive and imprecise in determining liability and assessing damages.

The insurance liability crisis is not limited to the medical profession, but is a societal problem pervading all segments of our population. Last year in the United States, there were 16.6 million lawsuits costing $60 billion. In 1962 there was only one $1 million award while in 1984 there were 400. The magnitude of the crisis is clearly demonstrated in the following examples: One insurance company must pay $260 million, plus $1,400 a month, to a man who was injured when he fell through a skylight while attempting to break into a school. New York City recently settled a case out of court for $650,000 with a man who had been seriously injured in a suicide attempt by jumping in front of a subway car. The man claimed that the train operator failed to stop the train in time to prevent his injuries. Many municipalities now find that the cost of liability insurance is exorbitantly high or not available to protect their employees. Ski areas, colleges, and high schools cannot obtain insurance for athletic programs. Restaurants and bars find themselves in a similar position as they have been found liable for drinking patrons.

According to the president of the newly-formed American Tort Reform Association, "Liability awards show no relationship with fact, fault, or fairness. Soon no one will write insurance at any price, and we will face bankruptcy, liquidation, or the deadly game of litigation roulette."[1]

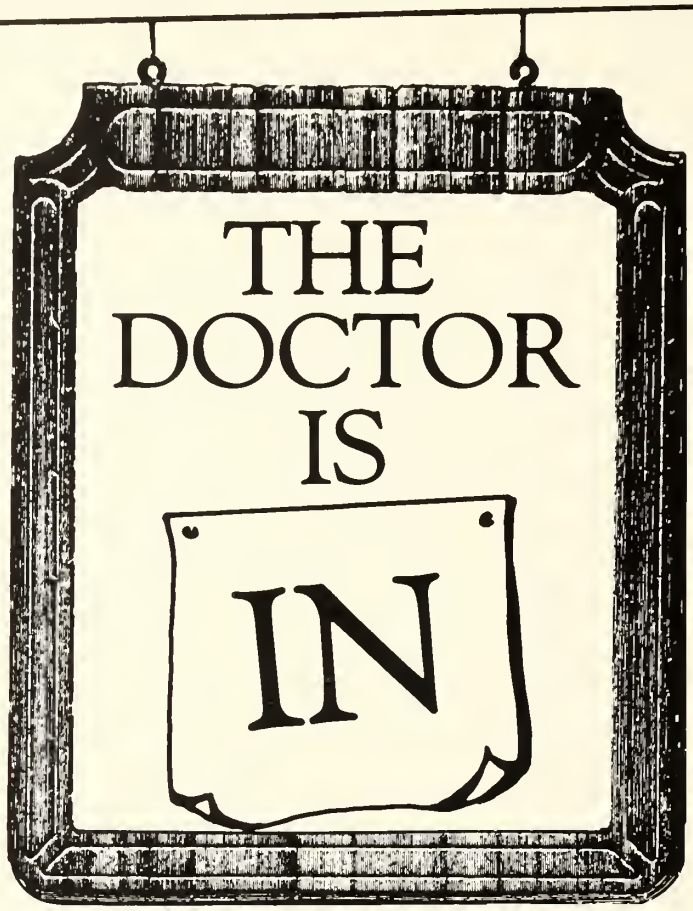
William McGill has observed, "The problem of malpractice insurance is but one form of a more general problem, the adversary character of modern American life. The problem of malpractice insurance must be seen in its larger philosophical context, because it has great implications not only for the practice of medicine, but for the functioning of society. As we begin to solve the malpractice problem, we shall begin to solve many other problems of an equally divisive character. It will probably take longer than a life-time to conclude such a monumental healing effort because the evil we now confront has been developing more than four decades."[2]

And Hans Sennholz has put the crisis in perspective: "It is futile to search for a scapegoat for this liability and insurance dilemma. It is fruitless to blame patients for turning into 'adversaries' eager to sue. The people are not 'out to get' their doctors. It is absurd to make lawyers the favorite scapegoats, to deride them as opportunistic parasites preying on the fears of patients and pocketing the lion's share of the awards. Attorneys are no worse than their clients, without whom they have no case. Similarly, it is foolish to conclude that every doctor is careless or incompetent. To search for an explanation of the malpractice insurance crisis, which is at least a decade old, is to seek for changes in economic doctrines and social mores that distinguish contemporary Americans from their forebears."[3]

References

[1] American Medical News, February 7, 1986, p. 16
[2] Columbia College Today, Winter 1985-1986. 13(1):24
[3] Private Practice, February 1986, p. 26

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BOOK REVIEW

Rhinitis

Rhinitis, edited by Guy A. Settipane, the New England and Regional Allergy Proceedings, Providence, Rhode Island, 1984, 167 pp.

Books devoted entirely to rhinitis are rare. A Rhode Islander, Doctor Guy A. Settipane, has filled the void. This work is a collection of papers previously published in the New England and Regional Allergy Proceedings, a quarterly medical journal of which Doctor Settipane is editor-in-chief. Cohesiveness, rare in this kind of collective work, is insured by the editor's introductory chapter as well as by four other chapters specifically written for this book. It is divided into three parts: basic science, clinical science, and unusual cases that can be associated with rhinitis.

The basic science section reviews basic nasal anatomy including newly-described neural reflexes. Physiology and pathology are fully covered. The allergic section describes in detail anaphylaxis, ie, antibodies, pollens and molds, epidemiology, and genetics. A clear review of skin testing is presented together with the importance of clinical interpretation in understanding the technique.

The nose, an interface between "lung and ambient air," its function in modifying the air we breathe, and its effect on the lungs are clearly explained by Doctor Donald F. Proctor in his chapter on this subject.

Several features of nasal rhinomanometry and experimental nasal challenges are reviewed in an interesting chapter by Doctor James A. McLean. This is the best review I have read on the subject. Since this book is intended at least in part for the specialist, it is regrettable that a description of methodology has not been included.

The grouping of clinical sciences should be of interest to the average reader who deals with these common disorders on a daily basis. Based on the previous basic science chapter, explanations are given for traditional treatment modalities. A chapter is devoted to the pediatric aspect of allergic rhinitis and will be of especial interest to pediatricians to whom early recognition may be important to forestall future morbidity in adulthood. The chapter on controlled studies of immunotherapy in allergic rhinitis contributes a critical review by Doctor William D. Franklin. The effectiveness of immunotherapy is supported by well-designed experimental studies, using random assignment of patients, placebo, and blind evaluation. This chapter is particularly instructive for those who have questioned the value of or the proper timing for this form of therapy.

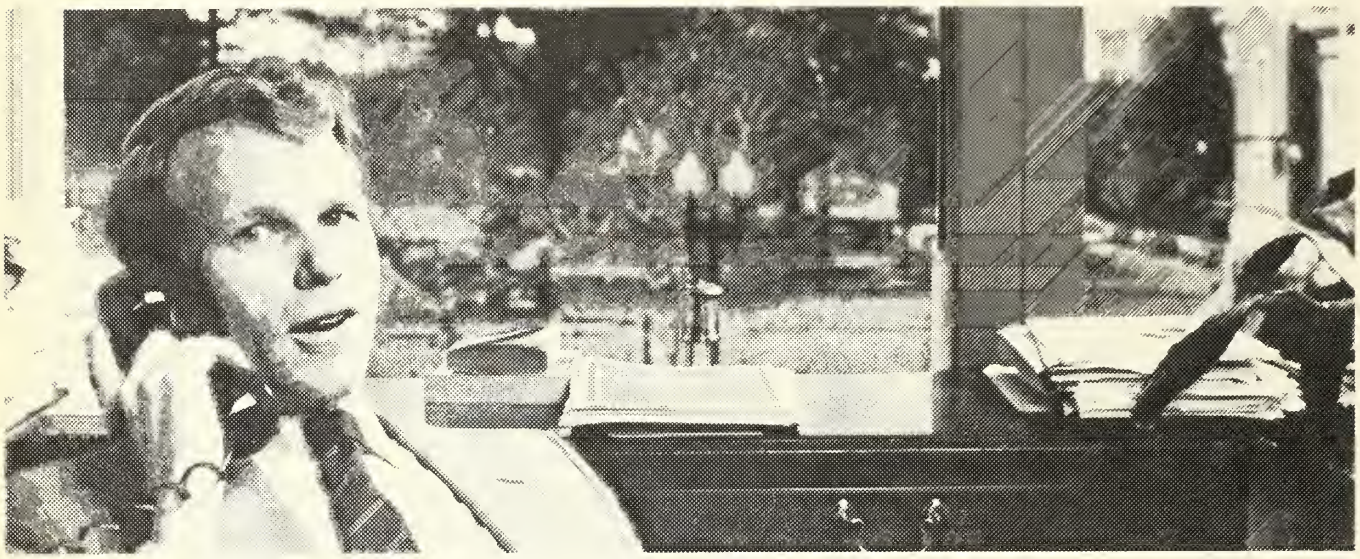
The last four chapters contain reports of unusual cases. Each case is well documented and fully-worked up, describing the disadvantages of possible misdiagnosis. They are of general interest, but especially so to specialists in the field.

While overlapping of material cannot be avoided in a multiple author book, it has been kept to a minimum. Despite the 24 chapters, four case reviews, and a meticulous index, the book occupies only 167 pages. It is at the present time the most comprehensive up-to-date survey of the field and should interest the scientist as well as the clinician because of the good balance between the basic science and the clinical sections.

The average *Journal* reader who surveys the table of contents may have the impression that this book is reserved for specialists in the field. As one goes beyond the titles, however, each chapter has an abstract and is written in a clear, concise, easy-to-read manner. Rhinitis, by no means a rare entity, is of interest to the general medical public as well as to the specialist.

Toussaint A. Leclercq, MD

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Noting that the results of violence in television series and motion pictures are not accurately portrayed, the American College of Emergency Physicians has urged producers of television and motion pictures to decrease the number of violent acts and to convey the results of violence realistically. Moreover, the College also has encouraged the motion picture and television industries to show all passengers in vehicles wearing seat belts. A common scene in top-rated action series involves a high-speed chase, resulting in a car crash. The characters walk away from the accident with little or no injury, even though they were not wearing seat belts.

Emphasizing the pervasive impact of television on the general public, especially children, Doctor Richard L. Stennes, ACEP President, said, "Many of our popular television shows and movies contain a lot of violence. Because children and young adults make up a large part of the viewing audience, it is important that they know what is and is not realistic in a violent scene so they will not endanger their lives and others because they do not understand the end results of their acts."

According to Doctor Stennes, potentially harmful or even fatal acts of violence are taken too lightly. A television series will show someone getting shot. The injury is treated as if it were a minor flesh wound, and the character is shown as healthy as ever in the next scene.

• • •

General Electric Medical Systems has recently introduced a high-speed, high-density optical storage and retrieval system for images made on its CT 9000 scanner. The CT 9000 Optical Disk Unit® features two-sided disk cartridges approximately the size of a 12-inch phonograph record, capable of permanently storing 12,000 images, which normally would require 30 magnetic tapes or 1,000 floppy disks. A specific examination can be located in five seconds from a fully-loaded cartridge and transferred to the operator console in about four seconds per image. The nonerasable disk cartridges have a minimum-useful data life of ten years. The CT 9000 database functions permit examination retrieval by combinations of patient identification, patient name, age, sex, orientation, and date. The optical storage unit consists of a disk drive and associated elec-

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tronics in a small freestanding cabinet. The CT 9000 scanning system, recently introduced by General Electric, can fit into an area as small as 400 square feet, making it an ideal choice for clinics or hospitals with limited space or for mobile use.

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THOMSON-CGR Medical Corporation recently launched a multimillion dollar national public awareness and education campaign to build recognition and acceptance of the benefits of mammography for the early detection of breast cancer in women. The campaign, encompassing all major aspects of public communication, begins this month and will continue throughout 1986. It will include advertisements in both broadcast and print media as well as a broad range of public and community relations activities.

The theme of the campaign centers on support by and testimonials from famous American women on the benefits of mammography. The first television and print advertisements feature actress Diahann Carroll discussing the benefits and importance of the early detection of breast cancer. These were broadcast on Good Morning America and the Today Show, among others. They will appear on television, in leading women's magazines, and in professional and scientific publications. In addition to technical and informational articles in national publications, public relations activities will focus on national health-care awareness and educational programs. These include community relations programs, presentations and seminars for women's and civic organizations, speaking engagements before medical and health-care associations, developing and distributing various informational materials, and support for a variety of programs and organizations working to expand the availability of mammography screening to the general population.

According to the American Cancer Society, only five per cent of the nearly 52 million US women over age 35 have undergone mammography screening.

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In a major postmarketing surveillance study recently published by Stuart Pharmaceuticals, Tenoretic®, a new beta-blocker diuretic product combining Tenorimin® (atenolol) with chlorthalidone, was found to control the blood pressure in 85 per cent of all patients evaluated. Results in 26,892 patients were consistently good

regardless of race, age, sex, or previous kind of antihypertensive therapy. The patients studied represented the full spectrum of hypertensive Americans. A total of 7,009 office-based primary-care physicians collected the data and an independent agency analyzed it. The Tenoretic Evaluation Program was designed to measure the effects of this new treatment on both blood pressure and general condition. The assessments were based on the reports of patients and their physicians. Patients already being treated for hypertension discontinued all other antihypertensive drugs and took only Tenoretic for 28 days.

The principal findings were that Tenoretic reduced blood pressure significantly, regardless of the patient's race, age, sex, or kinds of antihypertensive drugs he had taken before. Mean blood pressure of the 26,892 patients fell from 161/99 mm Hg before Tenoretic treatment to 140/86. Moreover, black and elderly patients responded as well as white and younger patients.

Tenoretic contains 50 mg or 100 mg Tenorimin (atenolol) and 25 mg chlorthalidone, an established thiazide-like diuretic. Since each drug acts for 24 hours, Tenoretic is taken only once a day. The combination is indicated for treating mild to moderate hypertension. Tenoretic 50, providing 50 mg Tenorimin, was used in the study. Because patients feel so well during Tenoretic treatment and have the convenience of taking their medicine only once a day, company officials believe that they are more likely to follow their antihypertensive regimen. This would eliminate a major cause of apparent "failures" of treatment.

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The American Institute for Cancer Research (AICR) has more than doubled its research grant funding for fall 1985 with a total of more than $1.3 million approved for cancer research relating to diet and nutrition at hospitals and universities across the country. The Institute has been awarding cancer research grants for the past three years for the study of cancer prevention through diet and nutrition. Its total commitment to cancer research has reached more than $4.4 million.

The new AICR grants will fund a variety of scientific approaches to the study of nutritional influences on cancer promotion. Among them will be a study at Johns Hopkins University School of Medicine on the role of such non-nutritive dietary additives as preservatives, flavorings, and food colors as possible inhibitors of



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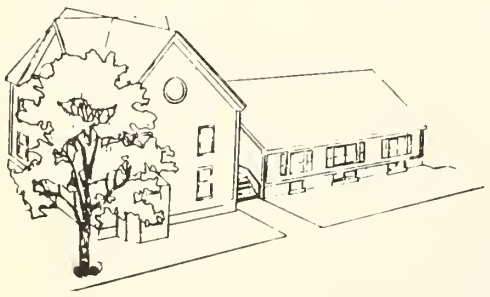
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cancer. Another study, to be conducted at Washington State University, will examine how the restriction of some amino acids can both block tumor growth and prevent resistance to drug therapy. Several of the AICR-funded studies will examine means for retarding growth of human tumors through dietary means. One such study at Harvard Medical School by Doctor Kenneth H. Falchuk will study the role of zinc and other metals in tumor growth. Doctor Andrew R. Hoffman will conduct a study at Stanford University to examine whether certain of the body's own peptides can be used to retard tumor growth. A continuing study at the Wistar Institute in Philadelphia will probe the relationship between fiber intake and colon cancer, with an emphasis on determining guidelines for fiber intake for those persons at risk for colon cancer.

• • •

The American Annson Company recently introduced its AnnsonResponse® practice management software package that improves productivity by computerizing much of the billing work in medical group practices. Specifically designed for group practices of five or more physicians, AnnsonResponse® helps to increase cash flow, facilitate insurance reimbursement and patient payments, and reduce the incidence of lost charges because it eliminates much of the time and error of manual entry. The system runs on the IBM/System 36 family of minicomputers and is an enhancement of the company's microcomputer-based "Doctor's Office Manager" practice management software for smaller practices.

All patient medical, financial, and insurance information is entered into the system at the time of the first visit, eliminating the duplication of information on insurance forms, ledger cards, patient statements, and mailings. Office cash flow is increased because the system automatically assigns charges based on procedures and automatically generates patient and insurance bills. AnnsonResponse® improves cash flow by tracking the differences between fee charges and actual reimbursement and automatically generating bank deposit slips. Moreover, company officials claim that physicians are better able to manage their time with a computer capability that provides round sheets by hospital in sequential room order. Both patient and physician routing sheets can be used as input documents for diagnosis and procedures performed.

10 YEARS

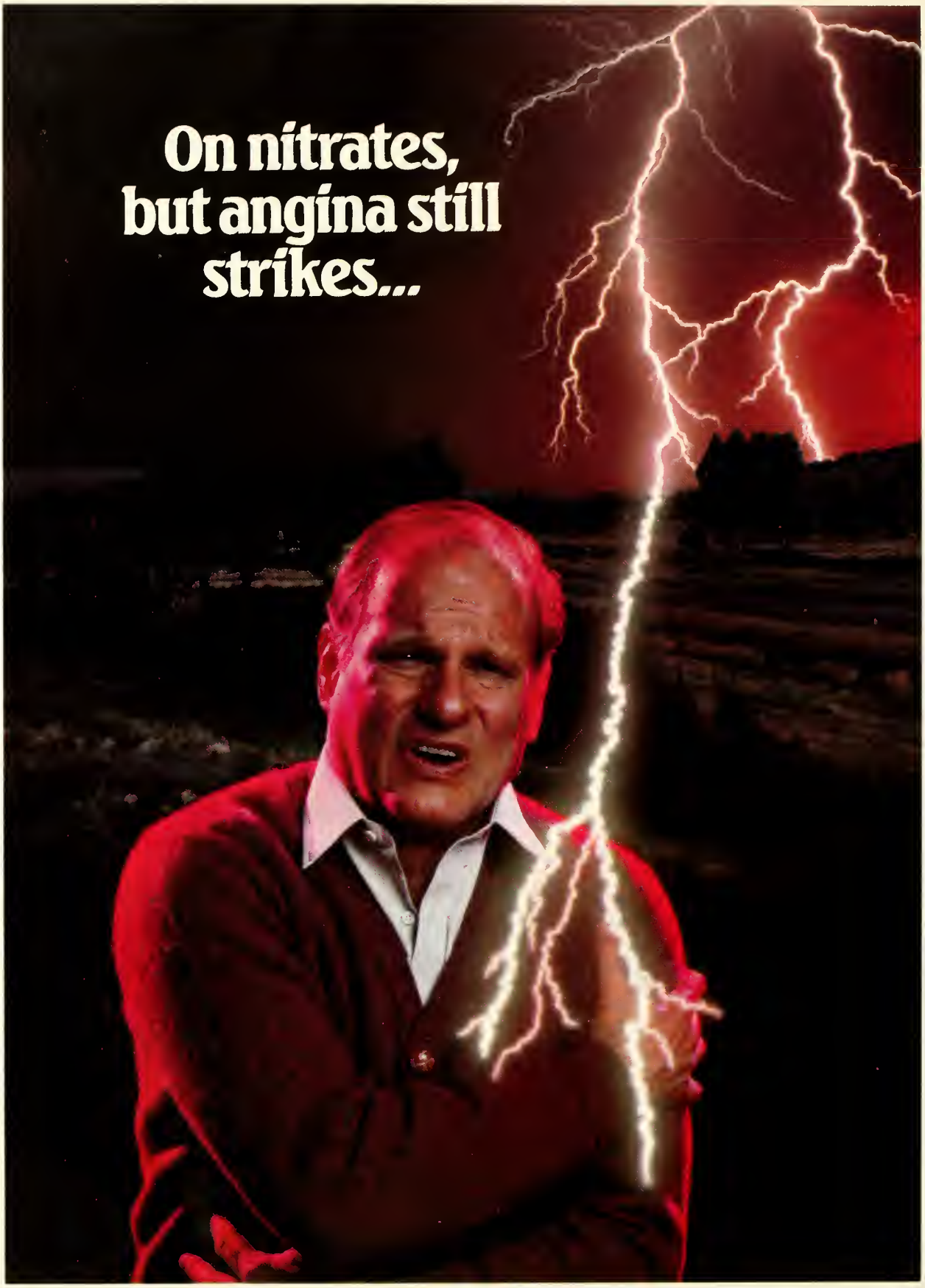
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Please see brief summary on following page

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Contraindications: Severe left ventricular dysfunction (see *Warnings),* hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (except in patients with a functioning artificial ventricular pacemaker), 2nd- or 3rd-degree AV block. **Warnings:** ISOPTIN should be avoided in patients with severe left ventricular dysfunction (e.g., ejection fraction < 30% or moderate to severe symptoms of cardiac failure) and in patients with any degree of ventricular dysfunction if they are receiving a beta blocker. (See *Precautions.)* Patients with milder ventricular dysfunction should, if possible, be controlled with optimum doses of digitalis and/or diuretics before ISOPTIN is used. (Note interactions with digoxin under *Precautions.*) ISOPTIN may occasionally produce hypotension (usually asymptomatic, orthostatic, mild and controlled by decrease in ISOPTIN dose). Elevations of transaminases with and without concomitant elevations in alkaline phosphatase and bilirubin have been reported. Such elevations may disappear even with continued treatment; however, four cases of hepatocellular injury by verapamil have been proven by rechallenge. Periodic monitoring of liver function is prudent during verapamil therapy. Patients with atrial flutter or fibrillation and an accessory AV pathway (e.g. W-P-W or L-G-L syndromes) may develop increased antegrade conduction across the aberrant pathway bypassing the AV node, producing a very rapid ventricular response after receiving ISOPTIN (or digitalis). Treatment is usually D.C.-cardioversion, which has been used safely and effectively after ISOPTIN. Because of verapamil's effect on AV conduction and the SA node, 1° AV block and transient bradycardia may occur. High grade block, however, has been infrequently observed. Marked 1° or progressive 2° or 3° AV block requires a dosage reduction or, rarely, discontinuation and institution of appropriate therapy depending upon the clinical situation. Patients with hypertrophic cardiomyopathy (IHSS) received verapamil in doses up to 720 mg/day. It must be appreciated that this group of patients had a serious disease with a high mortality rate and that most were refractory or intolerant to propranolol. A variety of serious adverse effects were seen in this group of patients including sinus bradycardia, 2° AV block, sinus arrest, pulmonary edema and/or severe hypotension. Most adverse effects responded well to dose reduction and only rarely was verapamil discontinued. **Precautions:** ISOPTIN should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of excessive pharmacologic effects. Studies in a small number of patients suggest that concomitant use of ISOPTIN and beta blockers may be beneficial in patients with chronic stable angina. Combined therapy can also have adverse effects on cardiac function. Therefore, until further studies are completed, ISOPTIN should be used alone, if possible. If combined therapy is used, close surveillance of vital signs and clinical status should be carried out. Combined therapy with ISOPTIN and propranolol should usually be avoided in patients with AV conduction abnormalities and/or depressed left ventricular function. Chronic ISOPTIN treatment increases serum digoxin levels by 50% to 70% during the first week of therapy, which can result in digitalis toxicity. The digoxin dose should be reduced when ISOPTIN is given, and the patients should be carefully monitored to avoid over- or under-digitalization. ISOPTIN may have an additive effect on lowering blood pressure in patients receiving oral antihypertensive agents. Disopyramide should not be given within 48 hours before or 24 hours after ISOPTIN administration. Until further data are obtained, combined ISOPTIN and quinidine therapy in patients with hypertrophic cardiomyopathy should probably be avoided, since significant hypotension may result. Clinical experience with the concomitant use of ISOPTIN and short- and long-acting nitrates suggest beneficial interaction without undesirable drug interactions. Adequate animal carcinogenicity studies have not been performed. One study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. *Pregnancy Category C*: There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor and delivery only if clearly needed. It is not known whether verapamil is excreted in breast milk; therefore, nursing should be discontinued during ISOPTIN use. **Adverse Reactions:** Hypotension (2.9%), peripheral edema (1.7%), AV block 3rd degree (0.8%), bradycardia: HR < 50/min (1.1%), CHF or pulmonary edema (0.9%), dizziness (3.6%), headache (1.8%), fatigue (1.1%), constipation (6.3%), nausea (1.6%), elevations of liver enzymes have been reported. (See *Warnings.*) The following reactions, reported in less than 0.5%, occurred under circumstances where a causal relationship is not certain: ecchymosis, bruising, gynecomastia, psychotic symptoms, confusion, paresthesia, insomnia, somnolence, equilibrium disorder, blurred vision, syncope, muscle cramp, shakiness, claudication, hair loss, macules, spotty menstruation. **How Supplied:** ISOPTIN (verapamil HCl) is supplied in round, scored, film-coated tablets containing either 80 mg or 120 mg of verapamil hydrochloride and embossed with "ISOPTIN 80" or "ISOPTIN 120" on one side and with "KNOLL" on the reverse side. Revised August, 1984 2385

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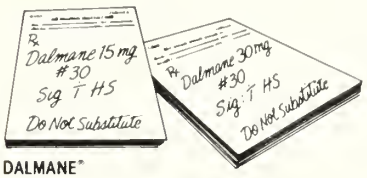
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References: 1. Kales J, *et al. Clin Pharmacol Ther 12* 691-697, Jul-Aug 1971 2. Kales A, *et al. Clin Pharmacol Ther 18* 356-363, Sep 1975 3. Kales A, *et al. Clin Pharmacol Ther 19* 576-583, May 1976 4. Kales A, *et al. Clin Pharmacol Ther 32* 781-788, Dec 1982 5. Frost JD Jr, DeLucchi MR. *J Am Geriatr Soc 27* 541-546, Dec 1979 6. Dement WC, *et al. Behav Med*, pp 25-31, Oct 1978. 7. Kales A, Kales JD. *J Clin Psychopharmacol 3* 140-150, Apr 1983 8. Tennant FS, *et al.* Symposium on the Treatment of Sleep Disorders, Teleconference, Oct 16, 1984 9. Greenblott DJ, Allen MD, Shoder RI. *Clin Pharmacol Ther 21* 355-361, Mar 1977



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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening, in patients with recurring insomnia or poor sleeping habits, in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

Contraindications: Known hypersensitivity to flurazepam HCl, pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patients to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Withdrawal symptoms rarely reported; abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase, and paradoxical reactions, *e.g.* excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect. *Adults*: 30 mg usual dosage, 15 mg may suffice in some patients. *Elderly or debilitated patients*: 15 mg recommended initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

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Rhode Island Medical Journal

May 1986
Volume 69, Number 5



Occupational disease in Rhode Island — see page 223

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J-6138 January 1986

"High blood pressure should be a red flag to screen for cholesterol..."[1]



Wyeth Laboratories
Philadelphia, PA 19101

If your patients have hypertension, they probably have high cholesterol too.

The Framingham Heart Study[2] showed that over two thirds of the 35 and older population in that study with systolic blood pressures over 145 mmHg also had serum cholesterol levels of 225 mg/dL or more, and 46% had levels above 250 mg/dL.

While many clinical laboratories still report 250 mg/dL as "normal" cholesterol, the NIH Consensus Development Conference Statement on Cholesterol and Heart Disease[3] stated that any level above 220 mg/dL is associated with a significantly increased risk of coronary heart disease.

You need to know, because high cholesterol parallels high blood pressure as a CHD risk factor.

Epidemiological studies and large-scale prevention trials have indicated that as with blood pressure, serum cholesterol levels are proportionately related to CHD risk.

Specifically, *"...for every 10 mmHg rise in pressure, there appears to be about a 30% rise in cardiovascular risk."*[4] *"...for every one percent you go up the American cholesterol scale, your subsequent rate of heart attack rises two to three percent."*[5]

And although the specific impact on CHD has not been determined, we know that many of the principal agents used to lower blood pressure actually increase cholesterol.

Wytensin® lowers blood pressure effectively without raising cholesterol.

While Wytensin is not a cholesterol-lowering agent and is not indicated for the treatment of hyperlipidemia, in controlled clinical trials[6] it caused a slight, sustained decrease in total cholesterol without reducing the HDL fraction or altering serum triglycerides.

At the same time, Wytensin lowered blood pressure as effectively as hydrochlorothiazide, propranolol, clonidine or methyldopa. Drowsiness and/or dry mouth, the most frequent side effects noted with Wytensin, usually diminish or disappear over time. In fact, in double-blind studies to date, discontinuance of therapy for all side effects occurred in about 13% of patients.



WyTensin®
(guanabenz acetate)

Antihypertensive therapy that does not increase cholesterol

See important information on following page.

References: 1. Glueck CJ: Remarks in the symposium, *Blood Pressure, Cholesterol and Coronary Heart Disease*, Washington, D.C., March 31, 1985. 2. *The Framingham Study, An epidemiological investigation of cardiovascular disease*, Section 28, U.S. Dept. of Health, Education, and Welfare. 3. National Institutes of Health Consensus Development Conference Statement, 1984: Vol 5, No 7, p 4. 4. Chobanian AV: The influence of hypertension and other hemodynamic factors in atherogenesis. *Progress in Cardiovascular Diseases, XXVI* (3): 177, Nov/Dec, 1983. 5. Castelli WP: Remarks in the symposium, *Blood Pressure, Cholesterol and Coronary Heart Disease*, Washington, D.C., March 31, 1985. 6. Data on file, Wyeth Laboratories.

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WyTensin®
(guanabenz acetate)

Antihypertensive therapy that does not increase cholesterol

Brief Summary

Before prescribing, consult the complete package circular.

Indications and Usage: Treatment of hypertension, alone or in combination with a thiazide diuretic

Contraindication: Known sensitivity to the drug

Precautions: 1. Sedation. Causes sedation or drowsiness in a large fraction of patients. When used with centrally active depressants, e.g., phenothiazines, barbiturates and benzodiazepines, consider potential for additive sedative effects. 2. Patients with vascular insufficiency. Like other antihypertensives use with caution in severe coronary insufficiency, recent myocardial infarction, cerebrovascular disease, or severe hepatic or renal failure. 3. Rebound. Sudden cessation of therapy with central alpha agonists like **Wytensin** may rarely result in "overshoot" hypertension and more commonly produces increase in serum catecholamines and subjective symptomatology.

INFORMATION FOR PATIENTS. Advise patients on **Wytensin** to exercise caution when operating dangerous machinery or motor vehicles until it is determined they do not become drowsy or dizzy. Warn patients that tolerance for alcohol and other CNS depressants may be diminished. Advise patients not to discontinue therapy abruptly.

LAB TESTS. In clinical trials, no clinically significant lab test abnormalities were identified during acute or chronic therapy. Tests included CBC, urinalysis, electrolytes, SGOT, bilirubin, alkaline phosphatase, uric acid, BUN, creatinine, glucose, calcium, phosphorus, total protein, and Coombs' test. During long term use there was small decrease in serum cholesterol and total triglycerides without change in high density lipoprotein fraction. In rare instances occasional nonprogressive increase in liver enzymes was observed, but no clinical evidence of hepatic disease.

DRUG INTERACTIONS. **Wytensin** was not demonstrated to cause drug interactions when given with other drugs, e.g., digitalis, diuretics, analgesics, anxiolytics, and antiinflammatory or antiinfective agents, in clinical trials. However, potential for increased sedation when given concomitantly with CNS depressants should be noted.

DRUG/LAB TEST INTERACTIONS. No lab test abnormalities were identified with **Wytensin** use.

CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY. No evidence of carcinogenic potential emerged in rats during a two-year oral study with **Wytensin** at up to 9.5 mg/kg/day, i.e., about 10 times maximum recommended human dose. In the Salmonella microsome mutagenicity (Ames) test system, **Wytensin** at 200-500 mcg per plate or at 30-50 mcg/ml in suspension gave dose related increases in number of mutants in one (TA 1537) of five *Salmonella typhimurium* strains with or without inclusion of rat liver microsomes. No mutagenic activity was seen at doses up to those which inhibit growth in the eukaryotic microorganism, *Schizosaccharomyces pombe*, or in Chinese hamster ovary cells at doses up to those lethal to the cells in culture. In another eukaryotic system, *Saccharomyces cerevisiae*, **Wytensin** produced no activity in an assay measuring induction of repairable DNA damage. Reproductive studies showed a decreased pregnancy rate in rats given high oral doses (9.6 mg/kg), suggesting impairment of fertility. Fertility of treated males (9.6 mg/kg) may also have been affected, as suggested by decreased pregnancy rate of mates, even though females received drug only during last third of pregnancy.

PREGNANCY. Pregnancy Category C. WYTENSIN® MAY HAVE ADVERSE EFFECTS ON FETUS WHEN ADMINISTERED TO PREGNANT WOMEN. A teratology study in mice indicated possible increase in skeletal abnormalities when **Wytensin** is given orally at doses 3 to 6 times maximum recommended human dose of 10 mg/kg. These abnormalities, principally costal and vertebral, were not noted in similar studies in rats and rabbits. However, increased fetal loss has been observed after oral **Wytensin** given to pregnant rats (14 mg/kg) and rabbits (20 mg/kg). Reproductive studies in rats have shown slightly decreased live-birth indices, decreased fetal survival rate, and decreased pup body weight at oral doses of 6.4 and 9.6 mg/kg. There are no adequate, well controlled studies in pregnant women. **Wytensin** should be used during pregnancy only if potential benefit justifies potential risk to fetus.

NURSING MOTHERS. Because no information is available on **Wytensin** excretion in human milk, it should not be given to nursing mothers.

PEDIATRIC USE. Safety and effectiveness in children less than 12 years of age have not been demonstrated, use in this age group cannot be recommended.

Adverse Reactions: Incidence of adverse effects was ascertained from controlled clinical studies in U.S. and is based on data from 859 patients on **Wytensin** for up to 3 years. There is some evidence that side effects are dose-related. Following table shows incidence of adverse effects in at least 5% of patients in study comparing **Wytensin** to placebo, at starting dose of 8 mg b.i.d.

Adverse Effect	Placebo (%) n = 102	**Wytensin** (%) n = 109
Dry mouth	7	28
Drowsiness or sedation	12	39
Dizziness	7	17
Weakness	7	10
Headache	6	5

In other controlled clinical trials at starting dose of 16 mg/day in 476 patients, incidence of dry mouth was slightly higher (38%) and dizziness was slightly lower (12%), but incidence of most frequent adverse effects was similar to placebo-controlled trial. Although these side effects were not serious, they led to discontinuation of treatment about 15% of the time. In more recent studies using an initial dose of 8 mg/day in 274 patients, incidence of drowsiness or sedation was lower, about 20%. Other adverse effects reported during clinical trials but not clearly distinguishable from placebo effects and occurring with frequency of 3% or less: Cardiovascular—chest pain, edema, arrhythmias, palpitations. Gastrointestinal—nausea, epigastric pain, diarrhea, vomiting, constipation, abdominal discomfort. Central nervous system—anxiety, ataxia, depression, sleep disturbances. ENT disorders—nasal congestion. Eye disorders—blurring of vision. Musculoskeletal—aches in extremities, muscle aches. Respiratory—dyspnea. Dermatologic—rash, pruritus. Urogenital—urinary frequency, disturbances of sexual function. Other—gynecomastia, taste disorders.

Drug Abuse and Dependence: No dependence or abuse has been reported.

Overdosage: Accidental ingestion caused hypotension, somnolence, lethargy, irritability, miosis, and bradycardia in two children aged one and three years. Gastric lavage and pressor substances, fluids, and oral activated charcoal resulted in complete and uneventful recovery within 12 hours in both. Since experience with accidental overdosage is limited, suggested treatment is mainly supportive while drug is being eliminated and until patient is no longer symptomatic. Vital signs and fluid balance should be carefully monitored. Adequate airway should be maintained and, if indicated, assisted respiration instituted. No data are available on **Wytensin** dialyzability.

Dosage and Administration: Individualize dosage. A starting dose of 4 mg b.i.d. is recommended, whether used alone or with a thiazide diuretic. Dosage may be increased in increments of 4 to 8 mg/day every one to two weeks, depending on response. Maximum dose studied has been 32 mg b.i.d., but doses this high are rarely needed.

How Supplied: (guanabenz acetate) Tablets, 4 mg, bottles of 100 and 500; 8 mg and 16 mg, bottles of 100.

Revised 2/14/85

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Ad Council

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6. The lines are thirteen blocks long.
7. My mother won't let me.
8. I didn't sign up.
9. I'm going out of town.
10. Asthma runs in my family.
11. I forgot to eat this morning.
12. I'm allergic to flowering magnolia."



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Newsletter

RHODE ISLAND MEDICAL SOCIETY
May 1986

Herbert Rakatansky, MD, President
Wendy J. Smith, Editor

ANNUAL MEETING TO BE HELD MAY 30

Invitations are in the mail to the 175th Annual Meeting of the Rhode Island Medical Society, to be held Friday, May 30, 1986, Biltmore Plaza Hotel, Providence.

The day-long affair will begin at noon with a luncheon session featuring Doctor John J. Coury, Jr., President-Elect of the American Medical Association. The House of Delegates will meet at 2:00 pm, followed by the general membership meeting at 3:30 pm.

The 1986 Charles V. Chapin Orator will be William J. Curran, Frances Glessner Lee Professor of Public Health, Harvard University. Professor Curran is a frequent contributor to the New England Journal of Medicine. The inauguration of new officers will take place in a special ceremony at 6:00 pm and will include an address by Doctor Herbert Rakatansky, President, Rhode Island Medical Society.

The gala dinner dance will begin at 7:00 with a reception. The featured dinner speaker will be Senator John Chafee who will address national influences on medical care. Entertainment will be by the Debbie Waldman Group.

For registration materials and additional information, call the Society's offices at 331-3207.

SENATE APPROVES MALPRACTICE PACKAGE

The Rhode Island Senate recently approved an omnibus bill which contains 31 recommended reforms developed by the Legislative Commission on Medical Malpractice to alleviate the medical liability insurance crisis. Nearly two-thirds of the recommendations address the Board of Medical Review, the state disciplinary agency for Rhode Island physicians.

Under the version approved by the Senate and forwarded to the House for its consideration, licensure and disciplinary activities would be merged into one Board of Licensure and Discipline functioning under the aegis of the Rhode Island Department of Health. The new board would be required to investigate all formal complaints and notices of clinical privilege reductions and prepare an annual report citing the number of complaints and the number of cases investigated. Although the board's proceedings would be confidential, all disciplinary actions would be made public. As a result, all hospitals would be required to inform the board of any restrictions of privileges or other disciplinary actions taken against health care personnel. The board would be required to notify all licensed hospitals of any restrictions placed on health care providers by the board or other hospitals.

Two reforms were included to encourage witnesses of malpractice to report the incident to the appropriate peer review or hospital boards. The first reform would provide immunity from civil liability for any good faith reporting of suspected malpractice. The second would provide that no action, such as firing, be taken against any employee of a licensed health care provider for a good faith report.

A similar bill introduced at the request of Governor Edward D. DiPrete has died on the Senate side although a companion version is still under consideration by the House Judiciary Committee. The Rhode Island Medical Society had vigorously objected to several provisions in the Di Prete bill which would have required physicians to incriminate themselves. Another provision would have permitted, rather than mandated, the governor to seek advice from the Society concerning appointments to the Board. A third objectionable section would have allowed the Director of Health

MALPRACTICE REFORM (continued)

rather than the Board, to appoint staff and legal counsel.

Other important reforms in the omnibus package include:

- Prejudgment interest would accrue from the date a suit is filed or formal notification of a suit is given rather than from the date of the alleged incident.
- Expert witnesses would be board certified in the appropriate specialty.
- Plaintiffs filing frivolous suits would be responsible for the defendant's legal expenses.
- Periodic payments for awards greater than $100,000 would be considered.
- The collateral source rule would be amended to preclude duplicate payments.
- Cases with a potential for substantial settlements would be placed on an accelerated court schedule.

RIMS President Doctor Herbert Rakatansky emphasized that the bill provides only a starting point for significant tort reform. The Commission notably failed to act regarding caps on awards for pain and suffering or limits on attorneys' contingency fees. The Society and the Medical Liability Coalition had recommended a $250,000 cap on awards for non-economic losses and that contingency fees be limited on a sliding scale with ten per cent of all awards greater than $200,000.

The Senate omnibus package presently awaits consideration by the House Judiciary Committee which has received an extension of its deadlines because of the Belivacqua impeachment proceedings.

SENATE APPROVES FREEZE ON JUA PREMIUMS

Citing the recent request by the Joint Underwriting Association (JUA) as "gouging the physicians of this state," Senator Michael D. Forte, D, Tiverton, introduced a measure which would freeze malpractice insurance rates for one year starting May 1, 1986. The measure passed the Senate and was sent to the House for consideration.

The JUA had filed a request with the Department of Business Regulation (DBR) for a rate hike that would have doubled the premiums paid by 1,800 Rhode Island physicians and other health care providers. The JUA had sought a 104.6 per cent increase in premiums with claims limits of $100,000/$300,000, and 115.2 per cent for claims limits of $1 million/$3 million. If enacted, the annual premium for obstetricians, orthopedic surgeons, and other "high risk" specialists would reach approximately $51,600 per year. A separate surcharge ordered by the Department of Business Regulation would have raised this figure to more than $60,000.

"The JUA's request would have driven doctors out of the practice of medicine and severely affected the quality of medical care available in Rhode Island," said Doctor Herbert Rakatansky, presidenc of the Rhode Island Medical Society, who added,"We are pleased with the Senate's action for it demonstrates the seriousness of the crisis and its impact on health care."

Between 1980 and 1985, the JUA requested a total of 588 per cent in malpractice premium increases from the Department of Business Regulation. Only 139 per cent in rate hikes were granted, leaving the JUA with a $100 million deficit. In 1976, the JUA paid $400,000 in settlements comared to $11,492,000 in 1984. The number of claims paid with indemnity escalated from one in 1976 to 145 in 1984. The average loss per claim rose from $4,000 in 1976 to $79,000 in 1984.

COUNCIL AUTHORIZES LEGAL ACTION AGAINST JUA

The Council recently authorized legal action to stop a mandatory contribution by all Joint Underwriting Association policyholders to the JUA's stabilization reserve fund. In 1985, the Department of Business Regulation ordered the JUA to assess all current policyholders 16-2/3 per cent of their renewal premiums and all new policyholders 50 per cent of their initial premium as a mandatory contribution to the

COUNCIL SEEKS LEGAL ACTION (continued)

stabilization reserve fund. When the JUA was established in 1975, all policyholders were required to pay a 33 per cent assessment. The reserve fund acts as a buffer between any deficits incurred by the JUA and a direct assessment of the participating insurance companies.

In other actions concerning the JUA, the Council also requested that the carrier seek the guidance of the Society in developing its proposed merit-rating system. The Department of Business Regulation has ordered the JUA to develop a means of merit-rating policyholders so that physicians with a higher level of settlements would pay higher premiums. The Council also said that any rating system should be related to fault as determined by peer review and should be prospective in nature. Points should be assessed, the Council continued, for actual claims settled rather than suits filed. The Council also called for the JUA Board to adopt an installment plan for JUA premiums, effective with the July 1986 billing.

In other actions taken at its April 7 meeting, the Council:

- opposed a bill submitted at the request of Governor Edward D. DiPrete to merge the Board of Medical Review with the state licensure agency unless provisions requiring physicians to report themselves under certain circumstances were eliminated.

- withdrew an endorsement of a disability income insurance program sponsored by New England Life Insurance Company. At the recommendation of the Medical Economics Committee, the Council previously had endorsed the program provided no RIMS members lost their current coverage. It was later discovered that New England Life will not issue policies to physicians older than 60 years and that some RIMS members currently insured under the Society's program could lose their coverage.

- received an interim report from the Long-Range Planning Committee. A preliminary report will be presented at the Annual Meeting on May 30, 1986.

- approved bylaws changes which create a category of direct membership, add three new standing committees to the Society, and include the presidents of constituent societies as voting members of the Council.

- voted not to endorse the application of Health Care Review, Inc as the designated professional review organization for the state

- re-elected Doctors Frank W. Sullivan and Daniel Moore, Jr. to the Benevolence Fund for terms ending in 1988 and 1989 respectively.

AMA TO SPONSOR WORKSHOP FOR EMPLOYED PHYSICIANS

The American Medical Association is sponsoring a workshop for employed physicians immediately preceeding the 1986 Annual Meeting in Chicago. The primary purpose of the one-day program, to be held June 14, 1986, is to provide an open forum for communication between the increasing number of physicians whose major form of practice is under an employment arrangement and organized medicine. Between 1983 and 1985 the number of non-federal patient care physicians identified as being employed rose from 23 to 26 per cent.

The first half of the forum will provide an overview of the future of health care and medicine from an economic, sociological, and business perspective. Featured speakers include Doctors James H. Sammons, AMA Executive Vice-President; Uwe Reinhart, Professor of Economics, Princeton University; Elliot Freidson, Professor of Sociology, New York University; Royce Dienar, American Medical International, Inc; and Richard Robinson, California Medical Association. During the second half, conference participants will identify common needs, share concerns, and develop solutions to professional problems.

There is no registration charge. For additional information, call or write the American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610 (312/645-4987).

PRACTICE MANAGEMENT QUESTION OF THE MONTH:

IMPROVING TELEPHONE ACCESSIBILITY

Availability implies accessibility by phone as well as through convenient office hours. Twice as many married women are full-time employees as was the case 25 years ago. Many practitioners have largely ignored this significant demographic change in the United States. As a result, it may be increasingly difficult for some patients to reach your practice. Approximately 65 per cent of all married women are full-time employees. Fifty per cent of all women with children under five years of age work full time.

How does this trend affect your practice? For many practices, most of the appointment calls are made by women for themselves and for family members. It is increasingly difficult for working people to reach your offices during their working hours. According to AT&T, fewer than 50 per cent of all workers have access to telephones because many employees work in factories, stores, and offices where outgoing calls are restricted.

Practice management consultants suggest that most medical offices should have someone answering the telephone approximately one hour before normal working hours in your community. This does not mean that you are available for patient visits. Being accessible does not require anything more than one employee coming to work earlier than usual. If your phones are not covered before the traditional starting hours, the patient encounters yet another obstacle. The hour preceding normal starting hours for most medical offices is also the busiest hour for answering services. Patients calling your office may have to let the phone ring several times before it is answered. New patients may not bother to wait. The same problem occurrs if your office is "closed" for lunch.

Other phone availability ideas: Many practices close for four days over the Thanksgiving weekend. While a vacation may provide a much-needed break after a busy autumn, it may be wise to ask one employee to go to the office the day after Thanksgiving to cover incoming phone traffic.

Some physicians feel that their practices should not be on answering service for four sequential days. Even a good answering service is not a substitute for a competent employee representing the practice itself. Some of the practices which have a person covering the phone on the Friday following Thanksgiving give that employee a bonus day off during the Christmas holidays.

Some practices may observe religious holidays that are not uniform for the community. Consideration should be given to having an employee at the office managing the phone on such days as the Jewish holidays, Washington's birthday, Good Friday, Columbus Day, Election Day, and Veteran's Day.

It may also be beneficial if employee hours are staggered so that the telephones are covered for one hour at the close of the day. For a minimal charge, the business office of New England Telephone will evaluate your phone line to determine which periods are the busiest.

Rhode Island Medical Journal

May 1986
Volume 69, Number 5

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Rhode Island Medical Journal is owned and published by the Rhode Island Medical Society, 106 Francis Street, Providence, Rhode Island 02903, Ph: 401 331-3207. Single copies $2.00 — Subscriptions $15.00 per year (members of the Rhode Island Medical Society — $5.00 annually). Published articles represent opinions of the authors and do not necessarily reflect the official policy of the Rhode Island Medical Society unless clearly specified. Advertisements do not imply sponsorship or endorsement by the Rhode Island Medical Society. Second class postage paid at Providence, Rhode Island and at additional mailing offices. **ISSN 0363-7913**

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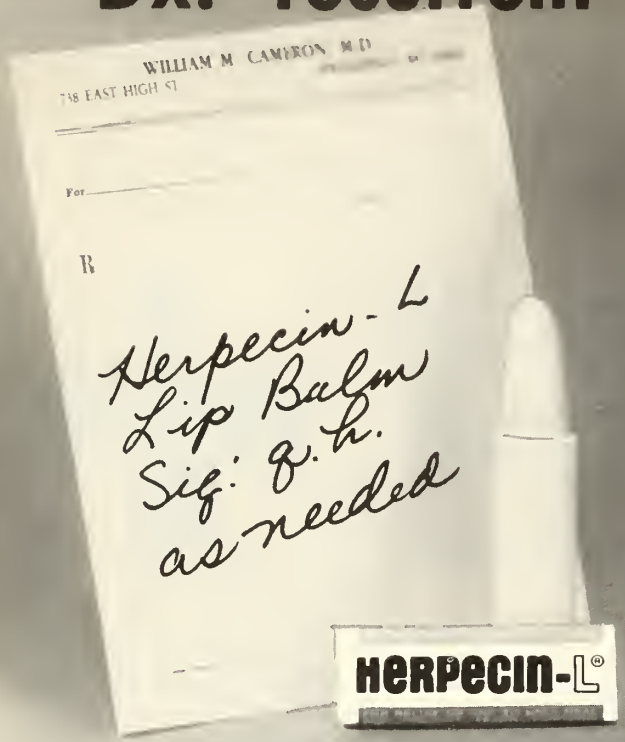
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Wendy J. Smith

COVER:

Occupational disease is a major cause of lost time at work. A new Rhode Island law, however, facilitates the treatment of work-related disorders. See page 223.

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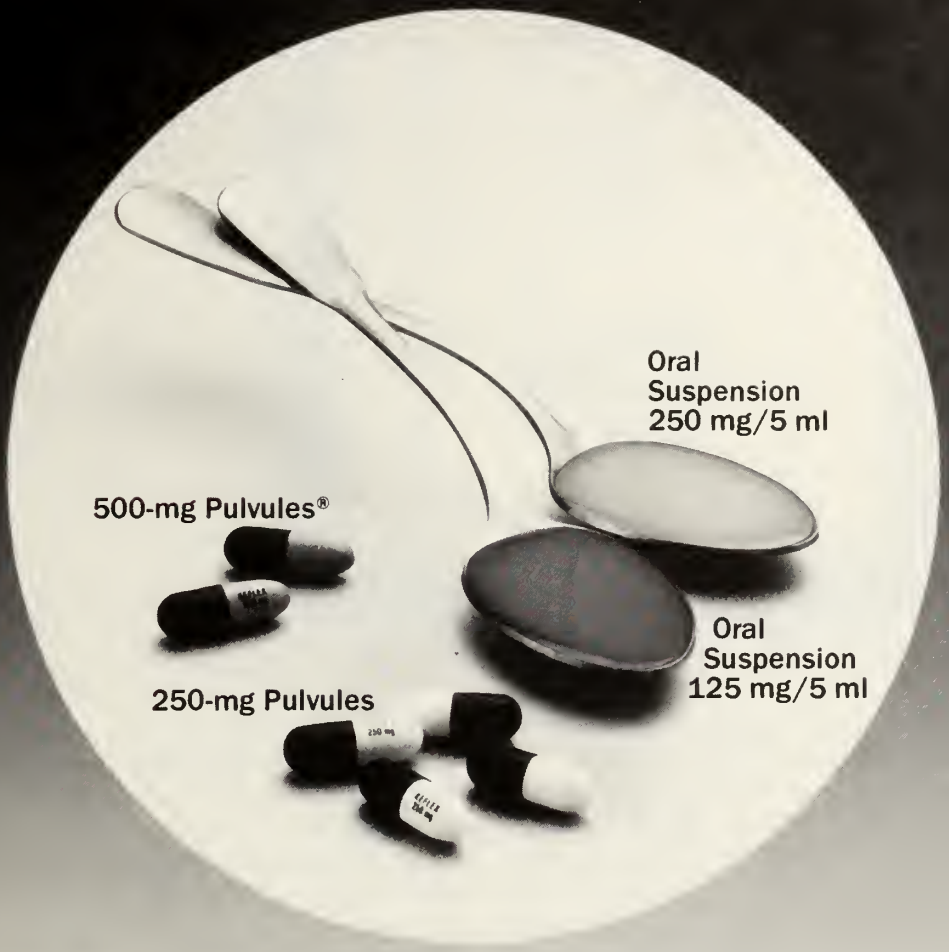
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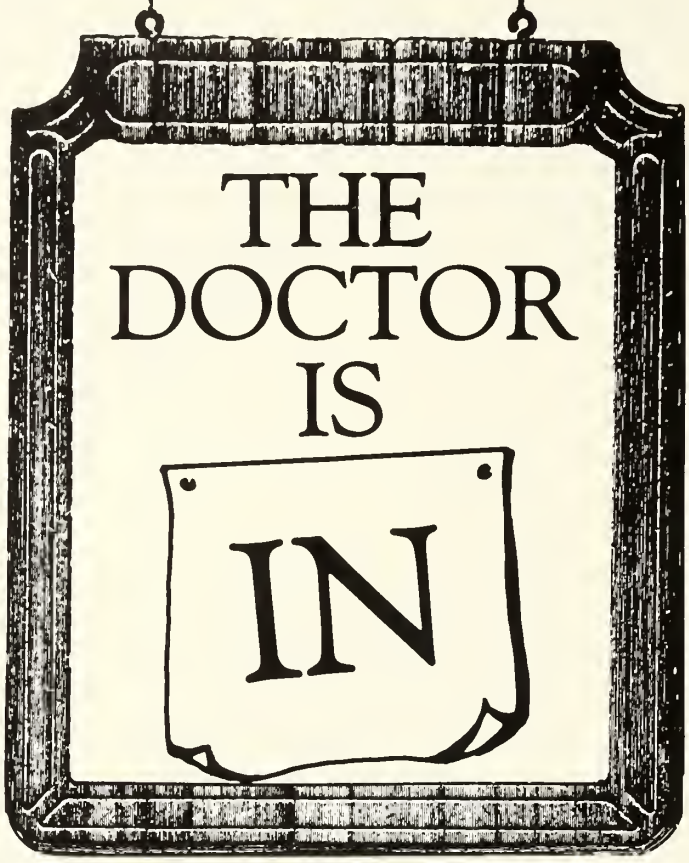


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EDITORIAL

Quality Assessment of Medical Care

Until recent years physicians of this country enjoyed wide freedoms regarding most aspects of the practice of medicine. By the middle of this century the medical profession had gained an exceptional degree of control over those aspects of medicine which pertain to patient care. Paul Starr's definitive, yet skeptical treatise, *The Social Transformation of American Medicine*, recently outlined this historic development. During the present decade, however, several new forces entered the medical arena and began to challenge the primacy of the medical profession over many aspects of medial care. Rapidly emerging technologies began to accelerate costs and thereby attracted the attention of those who bore the financial consequences. An increasingly skeptical public began to view doctors less charitably. As a result malpractice litigation and the consequent posture of "defensive" medicine began to influence the way physicians managed their patients. The federal government, through Medicare and more recently the DRGs, is exerting pressure on hospitals and physicians to adapt medical practice to economic strictures. The increasing influence of corporations and health maintenance organizations has also raised potential conflicts between financial and medical responsibilities. In this unsettling environment, the dominance of physicians over their activities is less certain than before. It is becoming increasingly difficult to maintain an excellent level of medical care.

When considering potential responses, one thing is clear: as long as physicians continue to insist on the highest standards of medical care for their patients, we are on solid ground and ultimately in accord with the demands of society. Since it is impossible to turn back the clock, efforts to maintain these standards should be made in a spirit of cooperation with the newer players in the arena.

The Rhode Island Medical Society is forming a Quality Assessment Committee which will attempt to evaluate the impact of these recent developments. It will be the Committee's role primarily to gather information from practitioners of medicine regarding the effects of government reimbursement policies, health care providers, and health maintenance organizations. It will act as a reference point for physicians of Rhode Island more accurately to delineate the impact of the "new players." These findings will be organized, analyzed, and reported to the membership of the Rhode Island Medical Society. The Committee will also meet with representatives of these organizations to present its findings and attempt to correct adverse trends. A number of other groups are studying these developments, notably the American Society of Internal Medicine and the American Medical Association. However, the focus of the Quality Assessment Committee will be on problems encountered in Rhode Island with its unique economic and demographic character. While focusing on problems that exist within the boundaries of the state, the Quality Assessment Committee will also remain in touch with other state societies and the American Medical Association, and will capitalize on similar efforts that are being initiated throughout the country.

Physicians of the Rhode Island Medical Society will soon be receiving questionnaires that attempt to survey the impact of these developments. Included will be a section in which specific examples of adverse (or beneficial) effects may be reported. Every physician is encouraged to complete at least the general portion of the form, so that a truly accurate picture of Rhode Island's climate can be obtained. Indeed, we are under some obligations to do this if we are in fact truly interested in assessing critically the many forces that influence our medical behavior. It is hoped that the Quality Assessment Committee will complement other recent efforts of the Rhode Island Medical Society, such as the committee to evaluate the competency of physicians and the well-established Impaired Physicians Committee. As these efforts develop Rhode Island physicians will more effectively shape their professional destiny and continue in the uncertain years ahead to safeguard the interest of our patients.

Boyd P. King, MD
Chairman
Quality Assessment Committee

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Speakers:

12:30 P.M.	John J. Coury, Jr., President-Elect, American Medical Association "The National Perspective: Events Affecting the Medical Climate."
4:00 P.M.	William J. Curran, J.D., LL.M., S.M.HYG. Professor Legal Medicine, Harvard University The Charles V. Chapin Oration "The Impact of Law on Medical Practice: Some Principles to Stem the Tide."
6:00 P.M.	Herbert Rakatansky, MD, President, Rhode Island Medical Society "The Present Condition of Medical Practice in Rhode Island and the Outlook for the Future."
8:00 P.M.	The Honorable John H. Chafee United States Senator "Federal Public Policies and Their Effect on Health Care."

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PRESIDENT'S PAGE



"Inherently Reasonable" Is Not Reasonable

The federal government seems to have a facility for inventing new phrases and refining old ones. The present Medicare regulations state that all payments must be "reasonable." At present the reasonable charge is considered to be the lowest of the following: 1) the actual charge; 2) the customary charge made by the usual supplier; or 3) the prevailing charge, which is defined as the 75th percentile of customary charges in the locality.

On February 18, a proposed rule was published in the *Federal Register* which would change the definition of "reasonable" to "inherently reasonable." The new criteria would include the following: (1) *Price mark-up:* This would include comparison between wholesale costs and retail prices in the entire region or nation. For example, laboratory charges in a doctor's office could be based on the costs of reagents and mark-ups for large national laboratories; (2) *Utilization:* A limit on certain services may be imputed to obtain cost effectiveness. Limits could be set on the number of certain procedures (eg, lens reimplants); (3) *Charges made to others:* Medicare could compare charges of individuals to charges made to large institutions by large volumes providers; (4) *Costs:* The charge could be compared with the cost of providing the service; and (5) *Area of charges:* Charges would be compared against other areas or even national averages.

There are a number of objections to this new scheme. You should become familiar with them as we shall soon be in a fight to prevent these changes from being implemented.

(1) The Medicare law establishes the mechanism by which the reasonable charge is made. There is no provision in the law which gives the



Herbert Rakatansky, MD

Secretary of Health and Human Services the right to change these provisions by regulation.

(2) It is apparent that the intent of this regulation is to save money, and the charges will be lowered to the lowest possible level based on the above five criteria. This is an arbitrary and "inherently unreasonable" method of fixing charges, as it does not take into account the variable economic and non-economic factors in different areas.

(3) The entire regulation is couched in vague terms. The Health Care Financing Administration (HCFA) will have the right to determine if a charge is "unreasonably excessive." These words

have no consistent definition and will be defined by HCFA at their convenience. No statutory right of appeal is included. The carrier may grant exceptions only if specific guidelines (not yet published) are met. There is no requirement that there be any guidelines at all. Other vague proposed terms include "unjustified differential" (between cost and charge), "cost-effective," and "other relevant factors."

(4) The law requires that any regulation which will have an effect on the economy in excess of $100 million must carry a statement with it describing its impact. The 1987 proposed budget estimates savings of over $100 million. The proposed regulation does not carry any such statement. There probably will be a significant impact on the provision of medical care in this country. Consumers and providers both will be affected. Such a program should not be implemented without knowing what its impact will be.

It is apparent that we should not like sheep accept these changes without protest. Our hope comes from the free and democratic society in which we live. If each member of the Rhode Island Medical Society were to write to our representatives and senators, we would have a strong voice. The AMA and the Society are expressing these thoughts to DHHS, but additional support from individual members will make our views more likely to prevail.

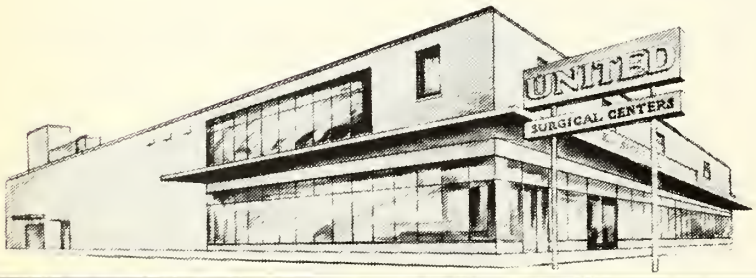
Please write and send a copy of your letter to me at the Society.

Finally, as this is my last opportunity to address you, my colleagues, in this format, I should like to thank you for the privilege of expressing myself in this rather personal and unfettered manner on a variety of topics which I have considered important. ■

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An Agenda for Rhode Island Children

Program Focuses on Maternal Health, Insurance Coverage for Preventive Care, Day Care Centers, and Adolescent Suicide

Richard A. Licht

My commitment to the youth of Rhode Island is based on a sound and simple premise: Investment of resources in our children will protect the state's future. Today's children must shoulder tomorrow's burdens . . . and lead us into the twenty-first century. Thus, all Rhode Islanders have a stake in helping healthy and educated children grow into self-sufficient, creative, and productive adults.

The young of Rhode Island are experiencing the consequences of a generation of social change. Families no longer fit the traditional mold of a father/breadwinner and mother/homemaker. In fact, the traditional family amounts only to 11 per cent of the population. The dual career family has become the dominant mode, with 60 per cent of all American families now in this category. Moreover, the number of single-parent families has doubled in the past decade and is continuing to rise. It is estimated that one-quarter of our nation's children are now being raised by a single parent.

Both the public and the private sectors must respond to these social and economic changes. To meet the needs of today's children, we must set an "agenda for children." By concentrating on a few key aspects, we will be better able to implement effectively new programs and policies to ensure the physical and emotional well-being of Rhode Island's youth.

As the Rhode Island Health Plan for children and youth states: "All children should be born to well and healthy mothers." Indeed, the first item on the agenda for children is the implementation of programs aimed at strengthening the state's maternal health programs. In Rhode Island, rates for infant deaths were higher than national rates in both 1983 and 1984. In fact, in 1983 they were the highest of all New England states. The state should adopt as its immediate goals: (1) A reduction in Rhode Island rates of infant mortality and low birthweight infants to the New England regional average; and (2) A sharp reduction in the differentials of risk experience based upon race, marital, and socio-economic status. To realize these goals, we must give immediate priority to increase the proportion of pregnant women who receive prenatal care in the first trimester to a level approaching 100 per cent. In addition, we must target enhanced management and surveillance efforts to mothers and children who are at high risk medically, socially, or both.

Preventive care, including routine physical examinations, screenings, and immunizations, must also be continued after birth during children's important formative years. Thus, the second item on the agenda for children is the elimination of gaps in financing of children's health services. A basic health care program should be available to all Rhode Island families regardless of their financial status. In order to promote well-utilized health care services for mothers and children, as a requirement for doing business in Rhode Island, all family health insurance policies and health maintenance organizations (HMOs) should provide pediatric health care and full maternity benefits without the hindrance of deductibles or co-payments. Preventive health care should be encouraged as a cost effective and medically sound practice.

Based on a presentation to the Rhode Island Chapter, American Academy of Pediatrics, October, 1985.

Richard A. Licht is Lieutenant Governor of the State of Rhode Island and Providence Plantations.

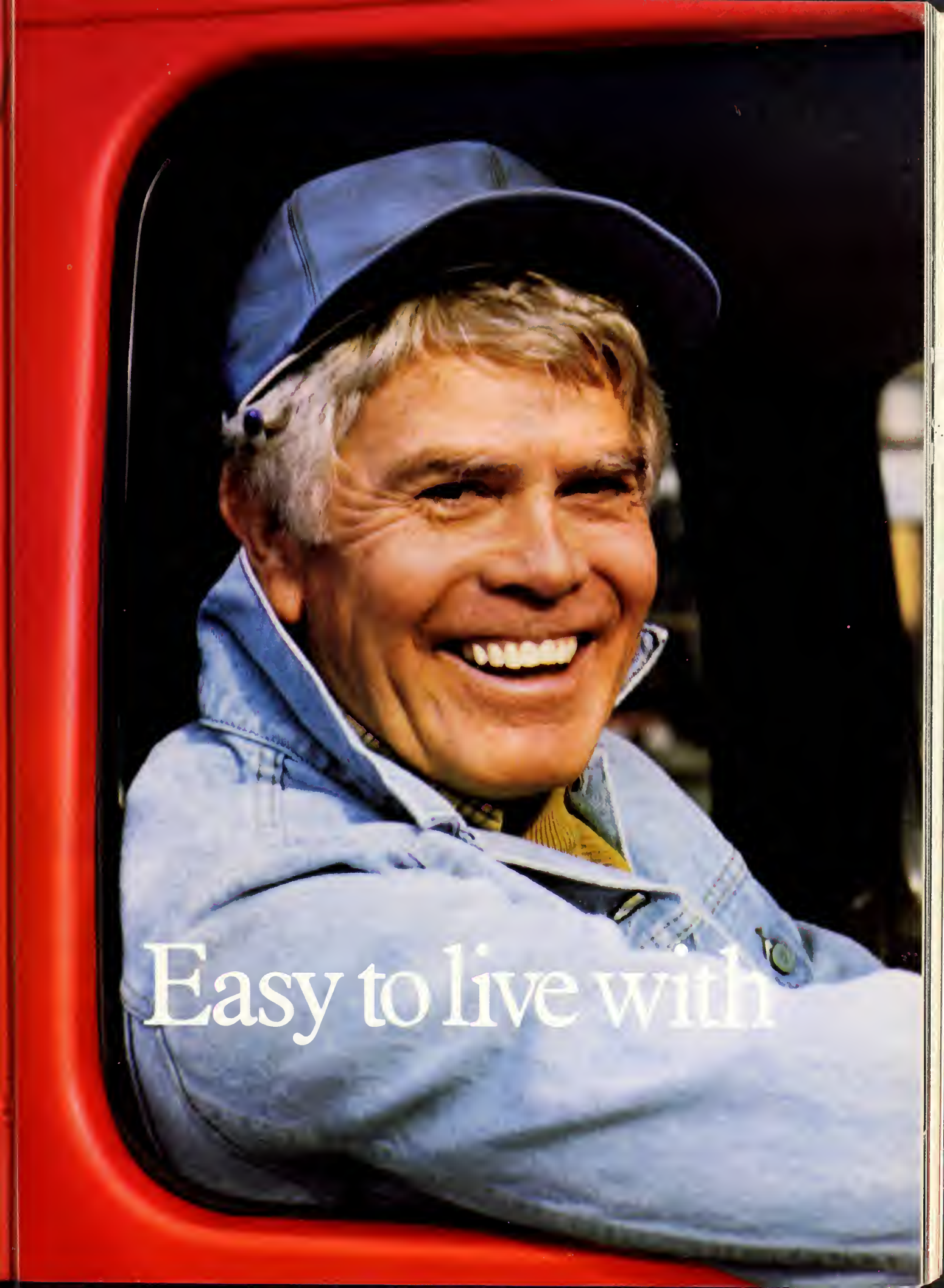
Quality child care and sound development does not end with medical well-being; it also includes proper supervision and nurture. Parents form such a large part of the work force that the child day care dilemma can no longer be ignored. It is both a family issue and an economic problem. The provision of available, affordable, and accessible child day care has a high priority. Helping to establish on-site and near-site day care programs should be a major objective so that working parents can hold good jobs close to their children. Increasing awareness about the need for and value of quality and affordable day care facilities in the community and at the workplace is essential.

Some noteworthy gains were made during the 1985 Rhode Island legislative session. However, we must continue to seek increased assistance for low-income families and financial and tax incentives to encourage the establishment of all-day and after-school day care programs by businesses and others.

The final item on the agenda for children is the crisis of adolescent suicide. Our job as parents, and as a society, is not complete until our children have their feet firmly planted in adulthood. Suicide is now thought to be the second leading cause of death among teens and young adults. Approximately 6,000 young Americans between the ages of 15 and 24 years commit suicide each year. Moreover, some experts indicate that one in every ten students is at risk, meaning that he or she has not only thought about suicide, but has planned it.

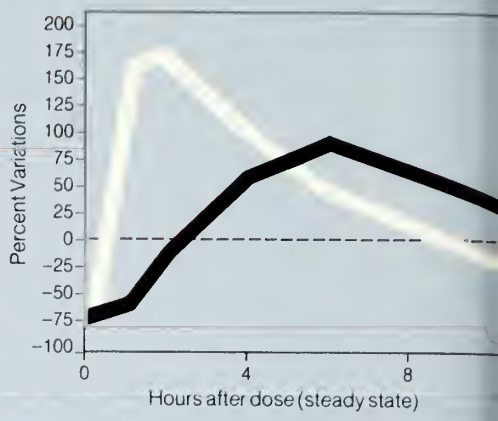
Rhode Island is leading the nation in addressing the problem of suicide among our young people. As part of the Rhode Island program of National Committee on Youth Suicide Prevention, a special legislative task force on adolescent suicide has been established and a pilot suicide awareness program has been initiated in our schools. The objectives of these measures are to compile a statewide data base on youth suicide, to determine the effectiveness of classroom suicide prevention programs, and to formulate policy and legislative recommendations for the governor and the General Assembly.

As a society, we have a collective responsibility to provide for our youth from prenatal care to adolescent suicide prevention. To ensure the success of the agenda for children, it is imperative that we learn to promote children's issues effectively. We must get the public and state policymakers to take notice of their importance to the future of our state. Meeting this responsibility will require commitment from concerned pediatricians and citizens of Rhode Island. You must get involved. You must provide the motivation and direction for Rhode Island's political leadership. Most especially, you must speak not for yourselves, but for the children and youth of Rhode Island. You are their lobbyists. You must continue to fight for our children . . . and the hope and future of the state. ■


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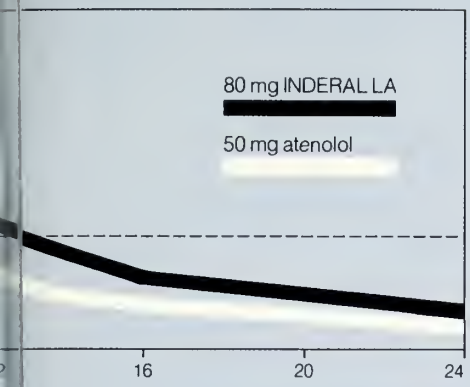
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CONTRAINDICATIONS

Propranolol hydrochloride (INDERAL® LA): Propranolol is contraindicated in 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with propranolol

Hydrochlorothiazide: Hydrochlorothiazide is contraindicated in patients with anuria or hypersensitivity to this or other sulfonamide-derived drugs

WARNINGS

Propranolol hydrochloride (INDERAL® LA): CARDIAC FAILURE Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated, and are receiving digitalis and diuretics Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or propranolol should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction following *abrupt* discontinuance of propranolol therapy Therefore, when discontinuance of propranolol is planned the dosage should be gradually reduced and the patient carefully monitored In addition, when propranolol is prescribed for angina pectoris, the patient should be cautioned against interruption or cessation of therapy without the physician's advice If propranolol therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute propranolol therapy and take other measures appropriate for the management of unstable angina pectoris Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

THYROTOXICOSIS Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker In one case this resulted after an initial dose of 5 mg propranolol.

MAJOR SURGERY The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures

Nonallergic Bronchospasm (eg, chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD, IN GENERAL, NOT RECEIVE BETA BLOCKERS INDERAL should be administered with caution, since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors

DIABETES AND HYPOGLYCEMIA Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes In these patients, it may be more difficult to adjust the dosage of insulin Hypoglycemic attacks may be accompanied by a precipitous elevation of blood pressure

Hydrochlorothiazide: Thiazides should be used with caution in severe renal disease In patients with renal disease, thiazides may precipitate azotemia In patients with impaired renal function, cumulative effects of the drug may develop

Thiazides should also be used with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma

Thiazides may add to or potentiate the action of other antihypertensive drugs Potentiation occurs with ganglionic or peripheral adrenergic-blocking drugs

Sensitivity reactions may occur in patients with a history of allergy or bronchial asthma

The possibility of exacerbation or activation of systemic lupus erythematosus has been reported

PRECAUTIONS

Propranolol hydrochloride (INDERAL® LA): GENERAL Propranolol should be used with caution in patients with impaired hepatic or renal function Propranolol is not indicated for the treatment of hypertensive emergencies

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure Patients should be told that propranolol may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure

CLINICAL LABORATORY TESTS Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase

DRUG INTERACTIONS Patients receiving catecholamine-depleting drugs, such as reserpine should be closely observed if propranolol is administered The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity, which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension

CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18 month studies, in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity There were no drug-related tumorigenic effects at any of the dosage levels Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug

PREGNANCY Pregnancy Category C Propranolol has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximal recommended human dose There are no adequate and well-controlled studies in pregnant women. Propranolol should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus

NURSING MOTHERS Propranolol is excreted in human milk Caution should be exercised when propranolol is administered to a nursing mother

PEDIATRIC USE Safety and effectiveness in children have not been established

Hydrochlorothiazide: GENERAL Periodic determination of serum electrolytes to detect possible electrolyte imbalance should be performed at appropriate intervals

All patients receiving thiazide therapy should be observed for clinical signs of fluid or electrolyte imbalance, namely Hyponatremia, hypochloremic alkalosis, and hypokalemia Serum and urine electrolyte determinations are particularly important when the patient is vomiting excessively or receiving parenteral fluids Medication such as digitalis may also influence serum electrolytes Warning signs irrespective of cause are Dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea and vomiting

Hypokalemia may develop, especially with brisk diuresis, when severe cirrhosis is present, or during concomitant use of corticosteroids or ACTH

Interference with adequate oral electrolyte intake will also contribute to hypokalemia Hypokalemia can sensitize or exaggerate the response of the heart to the toxic effect of digitalis (eg, increased ventricular irritability) Hypokalemia may be avoided or treated by use of potassium supplements, such as foods with a high potassium content

Any chloride deficit is generally mild and usually does not require specific treatment, except under extraordinary circumstances (as in liver or renal disease) Dilutional hyponatremia may occur in edematous patients in hot weather, appropriate therapy is water restriction, rather than administration of salt, except in rare instances when the hyponatremia is life-threatening In actual salt depletion, appropriate replacement is the therapy of choice

Hyperuricemia may occur or frank gout may be precipitated in certain patients receiving thiazide therapy

Insulin requirements in diabetic patients may be increased, decreased, or unchanged Diabetes mellitus which has been latent may become manifest during thiazide administration

If progressive renal impairment becomes evident, consider withholding or discontinuing diuretic therapy

Thiazides may decrease serum PBI levels without signs of thyroid disturbance.

Calcium excretion is decreased by thiazides Pathologic changes in the parathyroid gland with hypercalcemia and hypophosphatemia have been observed in a few patients on prolonged thiazide therapy The common complications of hyperparathyroidism, such as renal lithiasis, bone resorption, and peptic ulceration, have not been seen. Thiazides should be discontinued before carrying out tests for parathyroid function.

DRUG INTERACTIONS Thiazide drugs may increase the responsiveness to tubocurarine.

The antihypertensive effects of thiazides may be enhanced in the postsympathectomy patient. Thiazides may decrease arterial responsiveness to norepinephrine This diminution is not sufficient to preclude effectiveness of the pressor agent for therapeutic use

PREGNANCY Pregnancy Category C Thiazides cross the placental barrier and appear in cord blood The use of thiazides in pregnancy requires that the anticipated benefit be weighed against possible hazards to the fetus These hazards include fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult.

NURSING MOTHERS Thiazides appear in human milk If use of the drug is deemed essential, the patient should stop nursing

PEDIATRIC USE Safety and effectiveness in children have not been established

ADVERSE REACTIONS

Propranolol hydrochloride (INDERAL® LA): Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy

Cardiovascular Bradycardia, congestive heart failure, intensification of AV block, hypotension, paresthesia of hands, thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type

Central Nervous System Lightheadedness, mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to catatonia, visual disturbances, hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability; slightly clouded sensorium; and decreased performance on neuropsychometrics

Gastrointestinal Nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation; mesenteric arterial thrombosis; ischemic colitis.

Allergic Pharyngitis and agranulocytosis, erythematous rash; fever combined with aching and sore throat, laryngospasm and respiratory distress

Respiratory Bronchospasm

Hematologic Agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura

Auto-Immune In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous Alopecia, LE-like reactions, psoriasiform rashes, dry eyes; male impotence; and Peyronie's disease have been reported rarely Oculomucocutaneous reactions involving the skin, serous membranes, and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol

Hydrochlorothiazide:

Gastrointestinal Anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation, jaundice (intrahepatic cholestatic jaundice); pancreatitis, sialadenitis.

Central Nervous System Dizziness, vertigo; paresthesias, headache, xanthopsia

Hematologic Leukopenia, agranulocytosis, thrombocytopenia, aplastic anemia

Cardiovascular Orthostatic hypotension (may be aggravated by alcohol, barbiturates, or narcotics)

Hypersensitivity Purpura, photosensitivity, rash, urticaria, necrotizing angiitis (vasculitis, cutaneous vasculitis), fever, respiratory distress, including pneumonitis, anaphylactic reactions.

Other Hyperglycemia, glycosuria, hyperuricemia, muscle spasm; weakness, restlessness; transient blurred vision

Whenever adverse reactions are moderate or severe, thiazide dosage should be reduced or therapy withdrawn

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The Identification and Treatment of Occupational Illness in Rhode Island

Recent Legislation Facilitates Identification of Potential Harmful Substances

David G. Kern, MD, MOH
Edward Martin, MD

Physicians are often unhappy when patients raise the possibility of work-related disease. They envision paperwork, legal proceedings, the threat of an adversarial relationship with patients, and a deep sense of uncertainty about just what should be done. The physician may not know what questions to ask, what the answers would mean, and where to turn for help.

This discomfort is understandable given the character of medical school and postgraduate training and the perception that relevant resources are scarce. Neglect of the occupational history is reinforced by the social, legal, and economic realities that characterize interactions with employers, regulatory agencies, compensation systems, and the judiciary.

Clearly, there are significant barriers to the physician's considering the possibility of occupational disease. However, they are not as insurmountable as they may appear to be. Further, there are two inescapable facts. First, in entrusting their health care to physicians, patients have a right to expect that the nature and health significance of their working conditions will be ascertained. Second, the government has claimed that 100,000 Americans die of work-related illness each year. Both the magnitude of the numbers and the fact that occupational disease is preventable require physicians to be certain that their patients neither have been exposed to hazardous working conditions nor currently have an illness caused by such conditions. In this endeavor, the potential is available to improve the public health and the physical, psychological, and financial well-being of patients.

In 1970, with the passage of the Occupational Safety and Health Act, certain barriers began to fall. Congress declared its intent to "assure so far as possible every working man and woman in the Nation safe and healthful working conditions." The Occupational Safety and Health Administration (OSHA) and the National Institute for Occupational Safety and Health (NIOSH) were created. OSHA was charged with establishing and enforcing workplace health and safety standards. NIOSH was charged with conducting research, training health and safety professionals, and advising OSHA on standard setting.

It was in this climate that the diagnosis and treatment of occupational disease received increasing attention in the medical literature. Repeatedly the occupational history has been shown to have been indispensable to the diagnosis of work-related disease. Neglect of this history has led to delays in the detection, appropriate treatment, and elimination of specific work-related illnesses. To reduce this neglect, a number of papers in general medical journals have reviewed the essentials of the occupational history. Both algorithms and patient-completed history forms are now available to help physicians obtain a thorough data base regarding previous occupational illness, exposures to hazardous substances, and the use of personal protective equipment.

Until recently, an additional major obstacle confronted physicians. Patients were usually unaware of the names and properties of the chem-

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icals in their workplaces. At best, they might have known the trade names of the products they handled. A furniture stripper may have known that he was working with solvent XY-37, but would not have known it as dichloromethane or that it was being metabolized to carbon monoxide. The patient may have been working in a relatively confined space, but would not have known that local exhaust ventilation and an additional air supply were required. He could not have been expected to know that the intermittent headaches and chest pains experienced after work hours were due to elevated carboxyhemoglobin blood levels. Compounding the problem for the treating physician, employers often knew little about the chemicals in use at their facilities. What they did know they were under no legal obligation to reveal to a physician requesting this information.

During the 1980s, the problem of hazardous chemical product identification began to receive increasing attention from state and municipal governments. After a decade of frustrated federal action and inaction, the Rhode Island General Assembly in 1983 passed into law the Hazardous Substance Right-to-Know Act. In the process, the legislature had worked with organized labor, employer associations, firefighters, public health officials, members of the medical community, and the public to develop a law that would protect the health and safety of workers while not being so burdensome to employers as to be unworkable.

The Rhode Island act specifies that within three days of a request, an employer must provide to an employee a list of brand name chemical products which contain designated hazardous substances and are present at the work site. The employer must also provide a Material Safety Data Sheet (MSDS) for each of these brand name products. The MSDS describes the chemical composition of the named product, its characteristics, known health effects, and recommended protective measures. It is of critical importance that a worker's physician has the same right of access to this information and cannot be refused the information on the basis of trade secret claims.

OSHA has promulgated a federal Hazard Communication Standard that as of May 1986 has jurisdiction over employees in the manufacturing sector. Unaffected are workers employed in construction, agriculture, service industries, transportation, mining, and sales. Although it was the intent of OSHA to preempt municipal and state right-to-know laws, it remains to be seen what will happen in Rhode Island. Whatever the outcome of legal challenges to the OSHA standard may be, Rhode Island workers and their physicians will continue to enjoy the right of access to employers' lists of brand name hazardous chemical products and the corresponding material safety data sheets. In the remainder of this paper, we shall illustrate how useful this information is to the practicing physician.

Before Right-to-Know

Case 1: A 26-year-old warehouse manager presented with a nine-month history of cough, wheezing, and shortness of breath. Previously, he had enjoyed excellent health and had been swimming a mile a day. His symptoms first developed one month after he began generating polyurethane foam at work. The foam was being used as a packing material for automobile radiators. Initially, he had noted symptomatic improvement when he was out of work on the weekends. Because of this, he assumed that something in the foam process was responsible for his symptoms. He rearranged his work so as to be as far removed from that process as possible, but continued to have symptoms. He saw a pulmonary physician who prescribed bronchodilator medications. Unfortunately, the physician did not take a work history.

With no right-to-know law in effect, the starting materials of the foam had not been labeled and the material safety data sheets had not been made available. The MSDS information alone would have pinpointed the cause of respiratory symptoms at a time when the worker's disease was more likely to have been reversible. A year later, and without further exposure, this employee was still experiencing the symptoms of a classical occupational disease, toluene di-isocycanate induced asthma.

Clearly, under the Rhode Island Hazardous Substance Right-to-Know Act, the scenario would have been different.

After Right-to-Know

Case 2: A 34-year-old woman, employed as a housekeeper in a local hotel, was referred for evaluation of a pruritic rash involving her hands, arms, and neck. Her duties included cleaning guest rooms, changing linens, vacuuming, and scrubbing counters, sinks, toilets, and tubs. She had not been wearing gloves at work. At the time of her evaluation, she had already missed two of

the previous four weeks of work and had been seen in two hospital emergency rooms. She was using a corticosteroid cream with some improvement at the time of her appointment. She brought a copy of the Material Safety Data Sheet for the chemical cleaner that she had been using at work. The MSDS indicated that skin contact was to be avoided and that gloves were to be worn by anyone handling the substance. By wearing gloves she was able to return to work without further problem or lost time.

This case illustrates that simple changes in work practices and the use of protective equipment often can have a tremendous impact on whether a patient can safely return to work. Here, the wearing of gloves, as had been recommended by the cleaner's manufacturer, remedied the problem. Occupational illness is a major cause of lost work time. When physicians are provided with adequate information, they can make educated decisions as to how, when, and where their patients may safely return to work.

Case 3: A 57-year-old unemployed factory worker was referred for evaluation of chronic recurrent abdominal cramps, dizziness, and pleuritic pain. He had developed these symptoms while working with lacquer and paint thinners, stains, and contact cement. At his request, his employer had provided a respirator, which he had worn diligently. For a few months, his symptoms had diminished, but they then returned and intensified. He became anorectic, his weight began to fall, and he then lost his job. Following his medical evaluation, MSDSs were requested from his former employer. The first request was ignored. The second request, with a copy to the Department of Labor, was honored. Review of the MSDSs revealed both an explanation for the worker's abdominal symptoms and the need for either local exhaust ventilation or an air purifying respirator. It was subsequently determined that the respirator in use had not been properly maintained. After a few weeks out of work, the man's symptoms completely resolved.

This case illustrates that under Rhode Island law, physicians can obtain information from their patient's former employers. In any situation where a physician is finding it difficult to obtain requested information, personnel in the Right-to-Know Unit of the Rhode Island Department of Labor will assist.

Case 4: A 17-year-old male plastics fabricator presented with extremely painful bullous lesions on the tips of all his fingers. He had developed the problem within a few weeks of beginning the regular handling of two adhesives. He had not been wearing gloves. A call to the worker's employer revealed that no MSDSs were present at that facility. Fortunately, the employer was able to provide the brand names and addresses of the two chemical product manufacturers. Within minutes, the two manufacturers provided in great detail information on the chemical composition of their products. Although one of the manufacturers blamed the skin reaction on the worker's carelessness, he recognized his obligation under the law. The second manufacturer went so far as to offer samples of his product's raw ingredients so that we might isolate the responsible agent.

The information obtained by telephone in a few minutes allowed us to determine rapidly the two most probable causes of the bullous reaction, to make recommendations on work practices and protective equipment, and to inform the worker that he may well have developed a new allergic skin reaction.

Prior to passage of the Rhode Island Hazardous Substance Right-to-Know Act, we had never had such a straight-forward experience trying to identify chemical product information.

Summary

Practicing physicians should be encouraged in their efforts to identify occupational illness and hazardous workplace exposures. Although recording an occupational history is the *sine qua non* of such efforts, until recently it has been difficult for the physician to obtain identifying information on workplace chemical exposures. This has changed. The case reports in this paper illustrate the ease with which Rhode Island's medical practitioners can now obtain this identifying information through the state's Hazardous Substance Right-to-Know Act. Although the OSHA Hazard Communication Standard may eventually preempt the Rhode Island law, the same core information on toxic materials would still be available. With this information in hand, physicians are well situated for the identification, treatment, and prevention of occupational illness in Rhode Island.

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SPECIAL REPORT

Collective Bargaining and Physician Services

A 1973 report of the American Medical Association concluded that "the union movement's traditional emphasis on collective action through strict majority rule is ill-suited to professional values of individualism and autonomy." Also, the goals of the union movement, the report stated, were antithetical to those of organized professionals, namely, the advancement of medical science and the promotion of public and patient welfare. In the thirteen years that have lapsed since the AMA report, unionization has become a more attractive, yet less realistic, option for most physicians. Since 1975, the courts increasingly have subjected the practices of the learned professions and their associations to close scrutiny under federal antitrust laws.

Legal Risks of Collective Negotiations by Physicians

Joint negotiation of fees and reimbursement levels by groups of physicians or medical societies face considerable legal obstacles. In a landmark decision, *Arizona v Maricopa Medical Society*, the Supreme Court held that it was *per se* illegal for physicians to agree on the maximum fees that they would claim as payment for provided services. These maximum fee levels were determined by use of relative value scales and conversion factors.

A *per se* violation consists of conduct so fundamentally anticompetitive that it may be condemned without regard to the business justifications or proof of specific harm. Significantly, the Court in *Maricopa* was not persuaded that the unusual economic characteristics of the health care market justified an exemption to a *per se* analysis. The implications of this ruling are unmistakable and far-reaching. With little or no alteration, antitrust doctrines developed in the context of pricing behavior of business corporations will be applied to professional fee-related conduct. It is important to realize that the legal definition of "price-fixing" is much broader than its name would suggest. Any combination of competitors having the purpose or effect of raising, depressing, pegging, fixing, or stabilizing prices may be regarded as price-fixing.

Indirect agreements are violations as well. In *National Society of Professional Engineers v United States*, the Supreme Court invalidated an engineering society's ethical canon prohibiting professional engineers from discussing prices with potential customers until negotiations had resulted in the initial selection of an engineer. The Court remarked that while this was not "price-fixing as such," the canon amounted to a ban on competitive bidding that subsequently deprived the customer of the ability to compare prices in selecting engineering services.

Several variations on a common theme may be imagined where collective physician negotiations are concerned. Ordinarily, members of an association designate a common "agent" to bargain on their behalf toward an acceptable agreement. The negotiated purchase contracts probably would be executed bilaterally, although their content would be essentially identical among all similarly situated physicians. Most proposals call for nonexclusive and nonbinding participation by individual physicians, ie, each physician would remain free to reject the contract and negotiate individually for more satisfactory terms. No sanctions or enforcement mechanisms would be provided to compel acceptance of the jointly negotiated contract.

In the case of the National Collegiate Athletic Association, however, the Court found that use of an agent to negotiate contracts was a violation *per se*. It is likely that a nonbinding agreement

This paper is based on a December 1984 report from the American Medical Association Board of Trustees to the House of Delegates.

enforced by informal methods or coercion would be treated in the same manner. While a nonmandatory, nonexclusive agreement creates less risk of antitrust exposure, the danger is not significantly less.

Proving antitrust violations can be accomplished with circumstantial evidence. In *United States v. Container Corporation of America* the Supreme Court held that exchanges of information concerning the most recent price charged or quoted by sellers amounted to a *per se* unlawful price-fixing arrangement, even in the absence of an agreement to adhere to a price schedule. Moreover, the Supreme Court's recent decisions suggest that a combination to interfere with competitive price-fixing, even though not explicit price-fixing, will be subjected to liability under the *per se* test or a truncated version of the rule of reason. Under the *Container* rationale, furthermore, an inference of collusion may be drawn where the circumstances make it reasonably foreseeable that price stabilization or uniformity will result from such tampering with the free market pricing mechanism.

In the context of physician joint venture proposals, antitrust vulnerability is established by the expectation that a unified bargaining position will emerge from the process, by the tendency of group fee recommendations to be viewed as collective "demands," and by subtle influences on individual physicians to accept the contract terms ultimately offered. An informal "enforcement mechanism" could arise from the bargaining entity's practice of advising physician members as to the acceptability or relative worth of the offered terms. The unwillingness of third-party payers to negotiate with physicians who decline to accept the contract terms also would provide an impetus toward uniformity. These factors create a serious risk that even a nonexclusive, nonbinding collective negotiation arrangement would be viewed as a fee-stabilization combination implemented by tacit agreement of participating physicians.

Exemption from Antitrust Laws

Congress has enacted several statutes restricting both the applicability of the Sherman Act to labor and the power of the federal courts to enjoin labor activity. In the years immediately following passage of the Sherman Act, courts viewed the collaborative activities of workers as conspiracies and enjoined strikes as unlawful restraints of trade when a union's conduct or objectives were deemed socially or economically harmful. In the wake of these judicial decisions, Congress enacted several provisions designed to immunize labor unions and labor disputes from challenge under the Sherman Act.

Section 6 of the Clayton Act, adopted in 1914, declares that human labor is "not a commodity or article of commerce" and "immunizes from antitrust liability labor organizations and their members from lawfully carrying out their legitimate objectives." Simultaneously, in Section 20 of the Clayton Act, Congress restricted the powers of the federal courts to issue injunctions against strikes and boycotts that are undertaken in the employees' self-interest and that occur in the course of disputes concerning the terms or conditions of employment.

This protection was reemphasized in the Norris-LaGuardia Act of 1932 after the Supreme Court in the *Duplex Printing Press* case read the Clayton Act to apply only to union activities directed against an employer by its own employees. In the National Labor Relations Act of 1935, Congress expanded the organizational rights of labor, expressly recognizing employees' rights to organize in unions, bargain collectively, and engage in concerted actions. Congress also established the National Labor Relations Board (NLRB) to regulate labor-management relations. Moreover, the act imposes compulsory collective bargaining with respect to certain matters and establishes a certified organization as the exclusive negotiating representative.

The courts have held that a "labor dispute" within the meaning of the Norris-LaGuardia Act must grow out of labor relations, which implies the existence of a bona fide employer-employee relationship. To invoke the statutory labor exemption, the antitrust defendant must demonstrate (1) that the disputing parties are employer and employee and that the dispute affects some aspect of that relationship; or (2) that the employer-employee relationship of other parties constitutes the crux of the dispute which precipitated the antitrust claim.

"Therefore," the AMA report concludes, "when independent businessmen combine, even in the form of a labor organization, they may not invoke the statutory labor exemption to immunize conduct in restraint of trade, since their activities are undertaken to enhance their entrepreneurial interests rather than affect some employer-employee relationship."

It appears that a union of independently practicing fee-for-service physicians formed for the

purpose of collectively negotiating fees and reimbursement or practice conditions with third-party payers, group purchasers of service, and hospitals could not avail itself of a statutory exemption. Such a group would not be viewed as a bona fide labor organization, nor would its conduct relate to a "labor dispute" within the meaning of the Clayton and Norris-LaGuardia Acts. Clearly, since private fee-for-service physicians deal with insurers, purchasers, and hospitals as independent contractors, a dispute between their organization and these entities would not involve an employer-employee relationship.

Under the "right of control" test adopted by the National Labor Relations Board and most courts, the NLRB applies the same principles as do the courts in determining whether or not an individual is an employee or an independent contractor. When the party for whom services are performed retains the right to control the manner and means of his performance, particularly when this right extends to the details of work, the provider of services is considered an employee rather than an independent contractor. In applying the control test, the NLRB and the courts have identified many factors relevant to the inquiry, including: the type of services rendered and the degree of skill necessary to provide them, the right to hire and discharge, the method and determination of compensation, whether the person providing services is engaged in an independent business or enterprise, whether he has an independent entrepreneurial interest in the ventures, whether he stands to derive profit from the work of those under him, whether the relationship is of a permanent character, whether the tools and materials are furnished and maintained by the employer, and whether the employer has control of the premises where services are performed.

As applied either to the physician-patient relationship or the relationships among physicians, payers, and hospitals, the control test requires that independently practicing fee-for-service physicians be categorized as independent contractors rather than employees. Despite the fact that payers and hospitals have seized a substantial measure of economic control over the physician's practice, control over the mode and manner of the performance of medical services remains with the physician. Professional autonomy in the arena of medical decision-making, moreover, is protected from lay and corporate interference to a great extent by state medical practice acts. The NLRB and the federal courts undoubtedly would consider the physician's wide discretion in the exercise of professional skill and judgment as particularly persuasive evidence of independent contractor status.

The term "professional employee" refers to legal, engineering, scientific, and medical personnel who possess advanced specialized training and knowledge, are engaged in predominantly intellectual activities, and consistently exercise judgment and discretion in discharging their responsibilities. The term is not equivalent to "supervisory employees" who are excluded from the National Labor Relations Act (NLRA) by its own terms, or "managerial employees" who are excluded pursuant to the legislative policy of the Act. The fact that employees are professionals, however, does not preclude them from also being categorized as supervisory or managerial employees whose organization is ineligible for NLRB certification.

Even persons who are literally "employees" may be excluded from coverage under the National Labor Relations Act. Similarly, persons who admittedly possess certain employee characteristics may be denied recognition as "employees" for purposes of the Act. The NLRB consistently has adhered to the position that, while interns, residents, and clinical fellows possess characteristics of employees, they are primarily engaged in graduate educational training rather than serving the staffing requirements of hospitals. Accordingly, their status is that of students rather than "employees" entitled to the protection of the NLRA.

Although employed physicians may organize themselves for any lawful purpose, their right to do so is of limited value unless it is protected by the provisions of the National Labor Relations Act. Employers' attempts to discourage their organizational efforts as well as employers' subsequent conduct toward the union are not subject to the Act's sanctions against unfair labor practices. An employer is under no duty or legal compulsion to bargain with a physician organization that is outside the scope of the Act's protection. Moreover, retaliatory actions against striking employees may not be actionable under these circumstances.

Alternative Strategies to Promote Fair Representation

Two primary means exist by which independently practicitng physicians may increase their bargaining strength with third-party payers and

purchasers while lessening, to the extent possible, their exposure to risks to antitrust liability. Participation in certain types of Preferred Provider Organizations (PPOs) and Independent Practice Associations (IPAs), while not resulting in complete parity between physicians and payers, enables physicians to avoid risks of *per se* liability and may withstand scrutiny under the rule of reason if appropriately structured.

In PPO arrangements physicians negotiate fee schedules for medical services and peer review standards that serve to regulate the cost and quality of care. "Brokerage" model PPOs, ie, those structured around an independent intermediary that negotiates bilateral contracts between payers or purchasers and individual providers, integrated group practices, professional corporations, and institutions employing salaried staff, afford an optimal combination of enhanced physician bargaining strength and limited antitrust exposure.

IPA arrangements also facilitate physician input with respect to fees and quality assurance measures. By virtue of their integration of service and insurance functions, many IPA models have significant procompetitive proposals that may well preclude *per se* condemnation of fee setting by participating physicians. Notwithstanding doubts created by recent judicial decisions, it appears that physician fee determination under closed-panel IPA models in particular will be upheld as reasonable in light of the substantial business risks underwritten by physicians in many of these arrangements.

To the extent that physicians are willing to forego the advantages of solo and small group practice, another strategy for increasing bargaining power with manageable antitrust risks is consolidation of individual practices into larger group practice partnerships and corporations. Depending on the degree of concentration prevailing in the local medical services market, the merger of existing individual and group practices may proceed unhindered by antitrust intervention until relatively large physician enterprises predominate. As unitary economic enterprises, such merged ventures would be free to establish uniform fees subject only to the strictures of Section 2 of the Sherman Act, which deals with abuses of monopoly power.

Another private sector initiative available to physicians is participation in local health care coalitions — voluntary groups that attempt to address issues of accessibility and cost-effective use of high quality health care resources. The provider members of these groups realize that the coalition concept presents a unique opportunity for them to speak on cost control issues, and that failure to exploit this opportunity risks the danger of "solutions" imposed by the federal and state government. The knowledge and expertise that physicians can provide to a coalition will help to ensure that the quality of medical care, including the availability and access, is not overshadowed by cost considerations. Moreover, physician participation in coalitions increases the business community's understanding of medicine's position on health care issues; builds an improved relationship with government, labor, the public, and the business community; and maintains medicine's leadership role in the health care field.

One of the most effective and least hazardous methods by which medical societies may represent physician interests regarding fee and reimbursement issues consists of direct efforts to influence the actions and policies of state and federal governments. By lobbying legislatures and by participating in the processes of government agencies and regulatory authorities, medical societies may affect the substance of legislation enacted and the manner of its implementation. These activities are entitled to immunity from the antitrust laws under the *Noerr-Pennington* doctrine. This exemption is based on the First Amendment right to petition government and is fairly broad in scope. The protection relates to activities undertaken in good faith to persuade government to take specific actions or adopt certain policies, even if a competitor is disadvantaged by the proposed action and even if the result sought through lobbying is anticompetitive. This immunity does not apply when the petitioning activity is merely a sham to cover a petitioner's efforts to harm competitors directly.

SPECIAL REPORT

RIMS Income Survey

Wendy J. Smith

In a recent report to the Legislative Commission on Medical Malpractice, the Society announced that nearly 28 per cent of the respondents in a recent RIMS survey indicated plans to retire early as a result of the malpractice crisis. An additional 15 per cent said they planned to curtail their specialty practices, and nine per cent planned to seek employment where malpractice coverage is offered as a fringe benefit. Four per cent said they would leave Rhode Island, while three per cent planned to practice without insurance coverage. The survey, which generated more than 700 replies, was taken in response to a commission request for information concerning malpractice premium rates and physician income figures. The commission, which was appointed by the General Assembly in 1984, includes 18 legislators and public members, six of whom are plaintiff's attorneys.

Society members were asked to provide their net annual income (after expenses and before taxes) and their malpractice class designation, which determines the amount of their annual medical liability insurance premium. The largest group (47 per cent) earned between $50,000 and $100,000, followed by $100,000-$150,000 (21 per cent); $25,000-$50,000 (17 per cent); less than $25,000 (10 per cent); $150,000-$200,000 (4 per cent); and more than $200,000 (1 per cent). The average annual net income of Rhode Island physicians is $81,300.

This figure is consistent with data provided by the American Medical Association. Physicians practicing in New England have the lowest net annual income, $87,300, in the country. The point is further illustrated by the income levels of physicians in the neighboring state of Massachusetts, where the net annual income of $88,700 is the lowest of the ten most populous states in the nation. In comparison, Texas physicians net an average of $114,700, while Florida doctors earn $134,200.

When physicians' annual incomes are compared with the malpractice premiums, the crisis becomes immediately apparent. The problem is particularly acute for physicians in the Class V categories of obstetrics, neurosurgery and orthopedic surgery, where the annual premium to the Joint Underwriting Association is $23,750 for $1 million/$3 million coverage. In the majority of cases, this is a significant portion of the net income of these physicians. More than half of Class V physicians have a net annual range of $50,000 to $100,000. Their costs for medical liability coverage are 32 per cent of their income. Those earning between $100,000 and $150,000 pay 19 per cent of their net income in malpractice insurance premiums.

Addressing the practical implications of the crisis, Society President Doctor Herbert Rakatansky told the commission that an obstetrician with a standard practice would have to deliver 36 babies just to cover the cost of malpractice insurance. Particularly hardest hit, according to Rakatansky, are physicians working in neighborhood health centers which treat an indigent population at low reimbursement rates. These obstetricians must deliver 109 babies simply to pay for their liability coverage.

This threatening situation discourages new physicians from establishing practices in Rhode Island and at the same time accelerates the retirement rate among practicing physicians. An obstetrician trying to establish a practice in Rhode Island, for example, faces an insurance premium of $23,750 plus a one-time surcharge of $7,917. At the other end of the spectrum, nearly 30 per cent of the respondents to the RIMS survey said the malpractice crisis may force them into early

Wendy J. Smith is Managing Editor of the Rhode Island Medical Journal.

retirement. Approximately 39 per cent of the 1,821 physicians actively practicing in the state as of December 31, 1983 were 55 years or older. The retirement of a significant portion of this group would be serious at a time when the rate of physician growth in Rhode Island is the lowest of all 50 states. During the period 1980-1983, the rate of growth was 5.7 per cent in contrast to 10.8 per cent in Massachusetts, 12 per cent in Maine, 10.2 per cent in Connecticut, 14.6 per cent in New Hampshire, and 9.8 per cent in Vermont. Moreover, Rhode Island has 222 physicians/100,000 population while the New England average is 287/100,000.

While 15 per cent of the respondents indicated that they would curtail their specialty practices, there is widespread evidence that this already has taken place. In testimony before the February 5 open hearing of the Legislative Commission on Medical Malpractice, Doctor David F. Carter, a Pawtucket family physician, said that he has eliminated obstetrics from his practice and is considering no longer assisting at surgery. As President of the Rhode Island Chapter of the American Academy of Family Physicians, Carter reported that his situation is not unique among family practitioners, others of whom have similarly limited their practices. Doctor Clinton B. Potter, a Providence obstetrician/gynecologist, told the commission that he also is eliminating obstetrics because the threat of a lawsuit makes it "no longer possible to practice good obstetrics. And we refuse to practice mediocre medicine to satisfy the requirements of the legal profession."

The RIMS survey clearly demonstrates the gravity of the malpractice crisis in Rhode Island. Despite ample evidence to the contrary, the perception persists, perpetuated by those who stand to gain from the current tort system, that there is no malpractice crisis and that it is rather primarily a "pocketbook" concern of physicians. There is a similar misconception that insurance companies have accumulated huge profits at the expense of physicians and that ample funds are available to pay claims. Those who hold these misconceptions also are convinced the physician negligence is the only reason for the professional liability crisis.

The widespread impact of the malpractice crisis on patient care is evident. One of the factors responsible for the rising costs of medical care is the pass-through of direct premium costs and the price tag associated with defensive medicine, estimated to range between $15 billion and $40 billion annually. And it is likely that more and more patients will be denied access to specialized procedures associated with a high degree of risk.

Objective data on the numbers of claims, severity of claims, escalating cost of insurance premiums, and growing losses of professional liability insurers are evidence of a crisis far more serious than past ones. According to *Best's Insurance Management Reports*, for every premium dollar earned in 1984 in the professional liability industry, $1.10 was paid out for actual losses incurred. When loss adjustment expenses and overhead costs are added in, the combined ratio rose to approximately $1.66 for every premium dollar paid in 1984. As of December 1985, the Joint Underwriting Association of Rhode Island had massed a $100 million deficit over its nine years of operation.

A point made repeatedly to the Legislative Commission on Medical Malpractice is that physicians are highly educated and, for the most part, motivated by humanitarian concerns, yet held accountable for complex judgments often made in life-and-death circumstances. Although negligence does occur, physicians are too often sued for adverse results beyond their control. Even when negligence exists, the system for compensating patients has been crushed by almost limitless awards and the costs of determining liability. For these reasons, Rakatansky told the commission, the Society has sought reform legislation which will assure fair and adequate compensation for injuries resulting from negligence and resolve professional liability claims speedily and efficiently. ■

BOOK REVIEW

Coronary Prone Behavior

Treating Type A Behavior and Your Heart by Meyer Friedman and Diane Ulmer. Knopf-Random House, $15.95, 1985.

Doctor Meyer Friedman and his colleague Doctor Ray Roseman made a critical clinical observation some years ago: Patients, especially males, who exhibit several or more behavioral attributes subsequently have been shown to be vulnerable to myocardial infarctions. This behavioral constellation has been called Type A or coronary prone behavior. The epidemiologic associations, the pathophysiologic implications, the most accurate methods for appraising behavioral patterns, and the searches for beneficial therapies have been the subject of intense investigation for the past 25 years.

Friedman's pioneering work in making the original observations and in refining the clinical literature stands as a landmark in American medicine. Investigations over the following years, as reviewed in detail by two multidisciplinary scientific conferences sponsored by the National Heart, Lung, and Blood Institute, have pointed out the substantial uncertainty that still surrounds the syndrome, its impact, and its therapy. Through the years Friedman has continued his investigations. He has now made a second scientific contribution by reporting the first systematic study which purports to demonstrate a health benefit from efforts to modify coronary prone behavioral traits. Whether future research will lend additional weight to specific therapies, or even to the treatibility of Type A behavior, remains to be seen.

The book now offered by Friedman and Ulmer is enjoyable reading for the lay person. It presents the historical development of the coronary prone concept. It emphasizes, with many revealing anecdotal narratives, the essential clinical nature of the phenomenon and the observations made by Friedman and his team. The scientific basis of coronary prone behavior and its therapy is far more objectively presented in the scientific literature. The excitement, intrigue, and fun of a clinician-scientist pursuing his own observation produce enjoyable reading. It is understandable if Friedman has so identified himself with his "discovery" that he perceives it and writes of it as though most truths about the phenomenon have been discovered and it is now his role to inculcate his set of beliefs upon the remainder of the medical profession. The contributions which will be recognized in history are not in this book, but rather in the scientific literature — a literature which he stimulated and which many others have explored, expanded, and explained. This is a fun book providing the useful insights of a devotee. The reader should enjoy it, but should be persuaded only by data presented in other formats.

Richard A. Carleton, MD

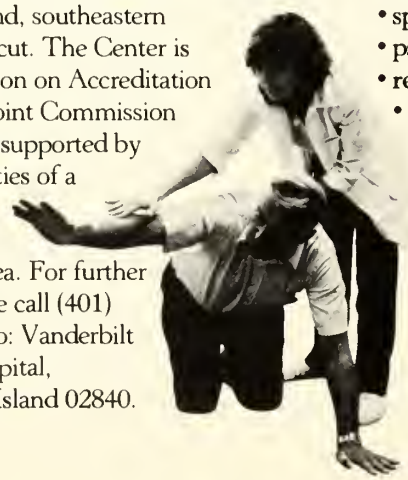


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LETTER TO THE EDITOR

Computers and the Medical Office

To the Editor:

I agree with almost all of the "rules" discussed by Patrick C. Garner in his paper, "Computers and the Medical Office," published in the December 1985 issue of the *Rhode Island Medical Journal.*

His perception of the problems with computerizing the medical office is quite accurate. As a volunteer consultant to the Cardiac Research Department of Rhode Island Hospital, not only have I helped many of the physicians become more "computer literate" but I also have helped install and maintain their patient billing systems.

My only point of disagreement with the article is that a solo practice can be effectively computerized with a single user computer. The cost of acquiring the necessary hardware and software has decreased dramatically in the past two years, primarily because of the popularity of the IBM Personal Computer. So much attention has been focused on this computer that many developers have converted their software to operate on the PC. Market forces have thus increased the quality of the software while decreasing the price and consequently dealer profit margins.

A single-user computer system can accomplish the primary task of improving cash flow by getting bills out and submitting claims to insurance companies. As Garner points out, automating secondary tasks such as computer scheduling of appointments is less than ideal and can interrupt the billing activity on a single-user system. However, as he says, "Some manual systems are as efficient and, at times, may provide greater flexibility."

Garner further states that the cost of a multi-user medical computer system begins as "low" as $15,000. Realistically, a solo practitioner can acquire hardware and software to automate billing and provide management reports for less than $7,500. This makes an effective management tool available to many practitioners. However, it is to the dealer's advantage to have the physician buy a system with a large dealer profit — perhaps a more complex system than the physician needs. As with cars, the extra cost is in the options, and therein lies the extra profit for the dealer.

There is a place in the solo practitioner's office for a single user PC with quality, well-established billing software that the dealer can customize for the forms used in the office. As the staff members participate with the dealer to design and implement the paper and computer flow, their understanding of the system is increased. Since many offices use the same software, the users create something of a mutual support network to address problems and unfamiliar solutions. This has allowed offices that could not otherwise afford a multi-user computer system to reap the benefits of increased financial control and enhanced patient satisfaction as well as a valuable research tool.

Harlan S. Hersey
West Warwick, Rhode Island

The Trustees of the Fiske Fund of the Rhode Island Medical Society are pleased to announce the

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The award for the 1986 Fiske Prize will be a maximum of $1,500. The Trustees reserve the right to award one or more prizes. The competition is not restricted to physicians.

Guidelines:

1) The original and one copy must be submitted by Sept. 1, 1986 to Secretary, Caleb Fiske Fund of the Rhode Island Medical Society, 106 Francis Street, Providence, Rhode Island 02903.
2) All papers must be double-spaced and should not exceed 10,000 words.
3) The award recipient must transfer copyright privileges to the Trustees of the Caleb Fiske Fund of the Rhode Island Medical Society. The paper will be considered for publication in the *Rhode Island Medical Journal*, subject to review by the Editorial Board.

HAVE YOU HEARD? . . .

Of all major anxiety disorders, social phobia is the most neglected in the mental health field, according to a report by Doctor Michael R. Liebowitz and his colleagues from the New York State Psychiatric Institute in the July 1985 issue of the *Archives of General Psychiatry*. Compared with panic disorder, agoraphobia, generalized anxiety disorder, and obsessive-compulsive disorder, little is known of its prevalence, severity, cause, or treatment. At its core, social phobia has the fear of seeming ridiculous to others. Its manifestations include fears of drinking, eating, shaking, blushing, speaking, performing, or writing in the presence of other persons. The anxiety of the social phobic appears to be confined to situations or the anticipation of situations in which the person might be scrutinized by others. In this, patients differ from sufferers of panic disorder or agoraphobia, to whom non-social situations can be profoundly disturbing. Moreover, patients with panic disorder are often comforted by the presence of a familiar figure while social phobics feel more comfortable if they can be alone.

Social phobic symptoms are frequently found among alcoholics, but the symptoms usually predate the drinking problems. In one study of 60 abstinent alcoholics, more than 60 per cent reported that alcohol was helpful in coping with their anxiety while seven per cent of the agoraphobics said that alcohol relieved their problems. Social phobia seems to begin early in life, characteristically between the ages of 15 and 20 and is thought to be more common in males. Vocational and social impairment is often significant. In one study, two of eleven patients were unable to work, two dropped out of school, four had abused alcohol, one had abused tranquilizers, six were blocked from professional advancements, and five avoided almost all contact outside their immediate families.

• • •

Monthly injected doses of haloperidol decanoate may be a satisfactory replacement for multiple oral doses of oral neuroleptic drugs for chronic schizophrenic patients, according to a study published in the June 1985 issue of *Current Therapeutic Research*. The problem with oral medication is that a high percentage of psychotic patients attending outpatient clinics either take their



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medication randomly or discontinue it entirely on their own. These defaults have been reported in 40 to 60 per cent of cases. Haloperidol decanoate is a depot drug with a prolonged therapeutic effect. The active molecule is attached to a fatty acid carrier, making the drug soluble in oil. Once injected into the body, it diffuses very slowly from the point of injection, and also finds its way into body fat, where it is released slowly from many different sites in the body.

Of 26 chronic schizophrenic patients selected for a recent study, 16 were paranoid with overt psychotic symptoms prior to treatment and eight were paranoids in remission. One aim of the study was to see if the new treatment could maintain the remitted status of the eight. Prior to treatment, patients were evaluated on the basis of the Brief Psychiatric Rating Scale. During treatment, scores improved and overt psychotic symptoms completely subsided in 16 cases. The eight patients who had been in remission not only maintained their remission status but showed some improvements. The mild degree of apathy they had manifested was replaced with a much more emotional involvement and a more satisfactory adjustment to social life.

• • •

A new study which traced the use of medications given to young children with febrile or viral illnesses in Michigan has found a decrease in the incidence of Reye Syndrome, perhaps as a result of decreased aspirin use among children. Researchers reported that parents who had heard of the association between aspirin and the syndrome were more likely to cease administering the drug. The study, published in the January 1986 issue of *Pediatrics*, noted that the associated decrease in the incidence of Reye Syndrome tends to support the hypothesis that the use of aspirin increases the risk for the development of the syndrome.

The researchers, from the Michigan Department of Health, University of Michigan School of Public Health, and the Centers for Disease Control, evaluated the possible changes in the frequency of aspirin use by interviewing 199 families in the Tecumseh, Michigan area. All families interviewed had children under 18 years of age. Based on the reported use of medications for colds or influenza between 1981 and 1983, fewer parents gave aspirin, but acetaminophen use did not change. The study noted that approximately 90 per cent of the parents who chose not to give aspirin for fever also gave medications

for colds or influenza which did not contain aspirin. These results suggest fewer children are receiving aspirin during illnesses than may precede Reye Syndrome.

The decrease in the number of cases of Reye Syndrome as reported yearly to the Michigan Department of Health since 1980 has also been observed nationwide. "The change most likely resulted from the widespread publicity about the association between aspirin and Reye syndrome. In 1983, parents in the study named television, neighbors, schools, health-care providers, and newspapers as sources of information on Reye Syndrome," the researchers report.

• • •

Preterm births (less than 37 weeks) were 20 per cent more common in women smoking at least one pack of cigarettes per day in a prospective study of 30,596 pregnant women in northern California, according to a study from the National Institute of Child Health and Development reported in the January 3, 1986 issue of *JAMA*. "This effect was strongest for births occurring before 33 weeks, where the excess was 60 per cent," say Doctor Patricia H. Shiono and her colleagues. The higher rate was not accounted for by differences in age, education, ethnicity, beginning of prenatal care, drinking, or other potential confounding factors, they add. Research results indicate a probable effect of smoking on time of parturition, in addition to the well-known effect on intrauterine growth retardation.

• • •

A recent study has found that serious and even fatal child abuse is committed more frequently by men than by women. Although few changes have occurred in the overall numbers of cases of injured or fatally-injured children, the proportion of severe injuries is now greater. This may alter the stereotype of the depressed, physically abusive mother as the primary perpetrator. Published in the January 1986 issue of *Pediatrics*, the study suggests that with more women in the workforce, men are spending more time caring for children. Another possible source of temptation is the use of unpaid, unmotivated "babysitters," such as boyfriends.

The report compared child abuse records from the King County (Washington) Medical Examiner's office for the years 1971-1973 and 1981-1983. The information was collected at King County's two major hospitals, Children's Or-



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thopedic Hospital and Harborview Medical Center. Eighty-one children were studied in the earlier period; 93 in the latter. For fatal cases, the earlier records show that 37 per cent of the perpetrators were men; in later years, 80 per cent were male. The proportion of severe injuries increased from 32 per cent for 1971-1973 to 54 per cent for 1981-1983. The children were 15 years of age or under, and all were thought to have suffered non-accidental trauma inflicted by a caretaker.

• • •

The stealing of children, although a rare event, is generally considered to be a crime committed by women. But, according to the *British Medical Journal*, a study of child stealing cases in England and Wales from 1977 to 1982 showed equal representation by both sexes (34 men and 34 women). Prior to this, most offenses in the region were actually committed by men. A group of British physicians tracked down and analyzed in depth six cases of men who stole children in London. Although the number of cases is small, it confirmed the physicians' hypothesis that men who steal children differ from women in that they abduct older children rather than babies, and their motivation is generally sexual. Five of the six had a history of sexual offenses against children, and in the sixth case, the judge reported remarks indicating a sexual motive. Two of the men had sadistic fantasies about children.

• • •

Interleukin 2 production drops 85 per cent after severe hemorrhage or accidental injury, making patients more vulnerable to life-threatening sepsis, according to a study from the UCLA Medical Center published in the December 1985 issue of the *Archives of Surgery*. Doctors Edward Abraham and Raymond Regan measured interleukin 2 production by mononuclear cells in 21 patients immediately after hemorrhage or trauma and found that production declined 56 per cent in patients with moderate injury and 85 per cent in severe injury, compared with controls. "These results indicate that marked abnormalities in cell-mediated immune function occur immediately after such injuries," the researchers say. The impaired immune response presumably makes such patients vulnerable to deadly infection.

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Contraindications: Severe left ventricular dysfunction (see *Warnings),* hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (except in patients with a functioning artificial ventricular pacemaker), 2nd- or 3rd-degree AV block. **Warnings:** ISOPTIN should be avoided in patients with severe left ventricular dysfunction (e.g., ejection fraction < 30% or moderate to severe symptoms of cardiac failure) and in patients with any degree of ventricular dysfunction if they are receiving a beta blocker. (See *Precautions.)* Patients with milder ventricular dysfunction should, if possible, be controlled with optimum doses of digitalis and/or diuretics before ISOPTIN is used. (Note interactions with digoxin under *Precautions.*) ISOPTIN may occasionally produce hypotension (usually asymptomatic, orthostatic, mild and controlled by decrease in ISOPTIN dose). Elevations of transaminases with and without concomitant elevations in alkaline phosphatase and bilirubin have been reported. Such elevations may disappear even with continued treatment; however, four cases of hepatocellular injury by verapamil have been proven by rechallenge. Periodic monitoring of liver function is prudent during verapamil therapy. Patients with atrial flutter or fibrillation and an accessory AV pathway (e.g. W-P-W or L-G-L syndromes) may develop increased antegrade conduction across the aberrant pathway bypassing the AV node, producing a very rapid ventricular response after receiving ISOPTIN (or digitalis). Treatment is usually D.C.-cardioversion, which has been used safely and effectively after ISOPTIN. Because of verapamil's effect on AV conduction and the SA node, 1° AV block and transient bradycardia may occur. High grade block, however, has been infrequently observed. Marked 1° or progressive 2° or 3° AV block requires a dosage reduction or, rarely, discontinuation and institution of appropriate therapy depending upon the clinical situation. Patients with hypertrophic cardiomyopathy (IHSS) received verapamil in doses up to 720 mg/day. It must be appreciated that this group of patients had a serious disease with a high mortality rate and that most were refractory or intolerant to propranolol. A variety of serious adverse effects were seen in this group of patients including sinus bradycardia, 2° AV block, sinus arrest, pulmonary edema and/or severe hypotension. Most adverse effects responded well to dose reduction and only rarely was verapamil discontinued. **Precautions:** ISOPTIN should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of excessive pharmacologic effects. Studies in a small number of patients suggest that concomitant use of ISOPTIN and beta blockers may be beneficial in patients with chronic stable angina. Combined therapy can also have adverse effects on cardiac function. Therefore, until further studies are completed, ISOPTIN should be used alone, if possible. If combined therapy is used, close surveillance of vital signs and clinical status should be carried out. Combined therapy with ISOPTIN and propranolol should usually be avoided in patients with AV conduction abnormalities and/or depressed left ventricular function. Chronic ISOPTIN treatment increases serum digoxin levels by 50% to 70% during the first week of therapy, which can result in digitalis toxicity. The digoxin dose should be reduced when ISOPTIN is given, and the patients should be carefully monitored to avoid over- or under-digitalization. ISOPTIN may have an additive effect on lowering blood pressure in patients receiving oral antihypertensive agents. Disopyramide should not be given within 48 hours before or 24 hours after ISOPTIN administration. Until further data are obtained, combined ISOPTIN and quinidine therapy in patients with hypertrophic cardiomyopathy should probably be avoided, since significant hypotension may result. Clinical experience with the concomitant use of ISOPTIN and short- and long-acting nitrates suggest beneficial interaction without undesirable drug interactions. Adequate animal carcinogenicity studies have not been performed. One study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. *Pregnancy Category C:* There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor and delivery only if clearly needed. It is not known whether verapamil is excreted in breast milk; therefore, nursing should be discontinued during ISOPTIN use. **Adverse Reactions:** Hypotension (2.9%), peripheral edema (1.7%), AV block: 3rd degree (0.8%), bradycardia: HR < 50/min (1.1%), CHF or pulmonary edema (0.9%), dizziness (3.6%), headache (1.8%), fatigue (1.1%), constipation (6.3%), nausea (1.6%), elevations of liver enzymes have been reported. (See *Warnings.*) The following reactions, reported in less than 0.5%, occurred under circumstances where a causal relationship is not certain: ecchymosis, bruising, gynecomastia, psychotic symptoms, confusion, paresthesia, insomnia, somnolence, equilibrium disorder, blurred vision, syncope, muscle cramp, shakiness, claudication, hair loss, macules, spotty menstruation. **How Supplied:** ISOPTIN (verapamil HCl) is supplied in round, scored, film-coated tablets containing either 80 mg or 120 mg of verapamil hydrochloride and embossed with "ISOPTIN 80" or "ISOPTIN 120" on one side and with "KNOLL" on the reverse side. Revised August, 1984 2385

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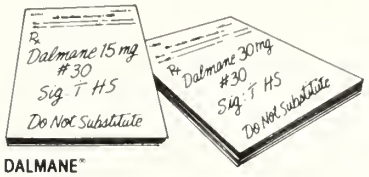
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References: **1.** Kales J, *et al Clin Pharmacol Ther 12* 691-697, Jul-Aug 1971 **2.** Koles A, *et al Clin Pharmacol Ther 18* 356-363, Sep 1975 **3.** Koles A, *et al. Clin Pharmacol Ther 19* 576-583, Moy 1976 **4.** Koles A, *et al Clin Pharmacol Ther 32* 781-788, Dec 1982 **5.** Frost JD Jr, DeLucchi MR *J Am Geriatr Soc 27* 541-546, Dec 1979 **6.** Dement WC, *et al. Behav Med*, pp 25-31, Oct 1978 **7.** Koles A, Koles JD *J Clin Psychopharmacol 3* 140-150, Apr 1983 **8.** Tennant FS, *et al* Symposium on the Treatment of Sleep Disorders, Teleconference, Oct 16, 1984 **9.** Greenblott DJ, Allen MD, Shoder RI. *Clin Pharmacol Ther 21* 355-361, Mor 1977



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Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase, and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

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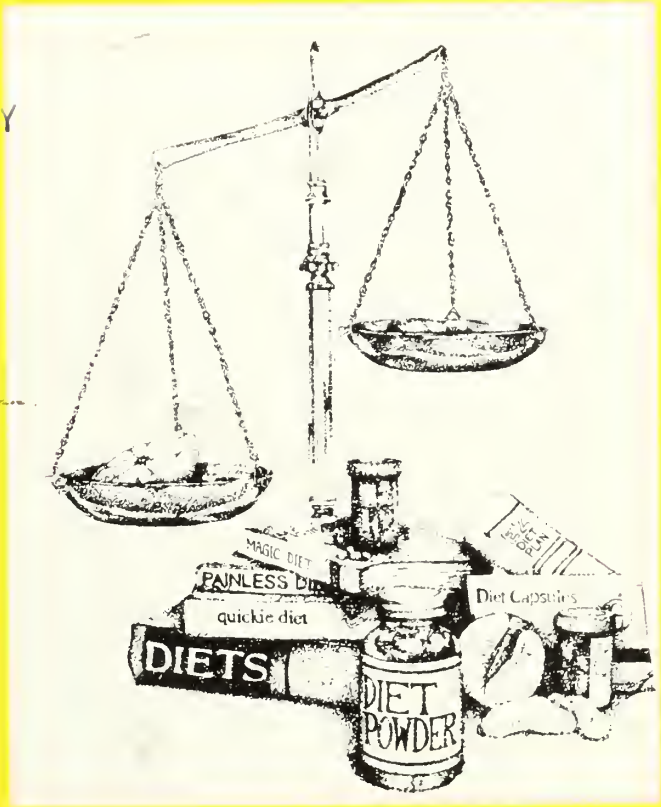
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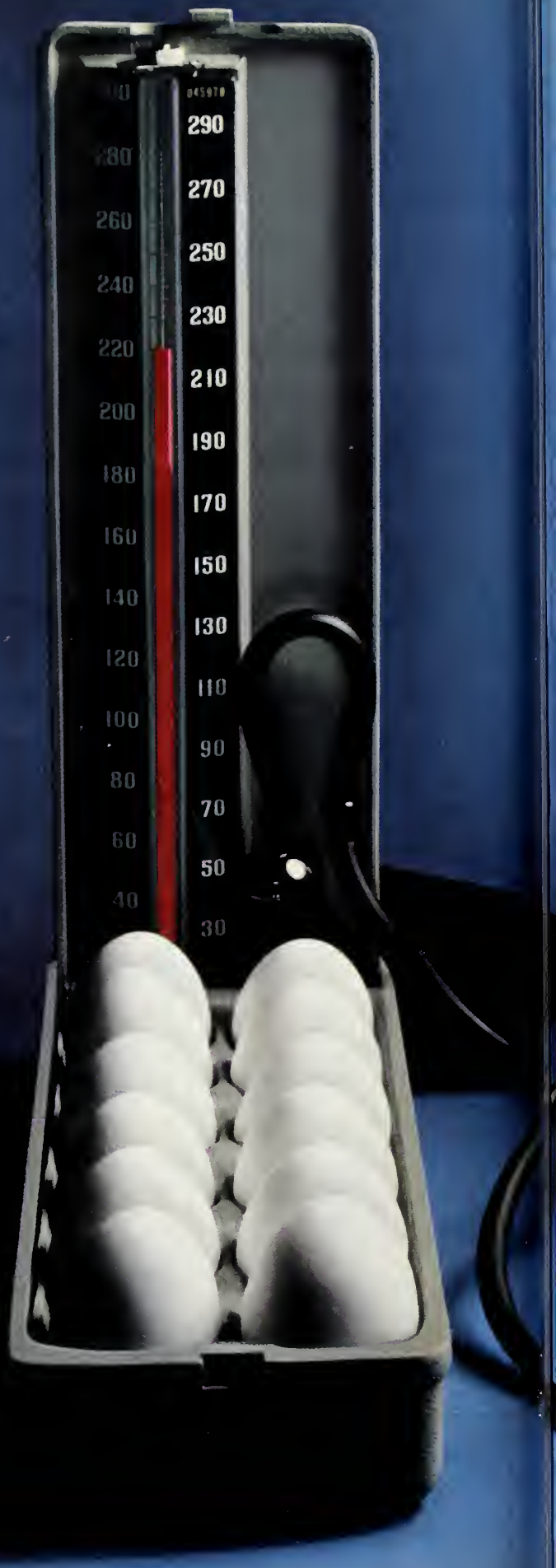
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While Wytensin is not a cholesterol-lowering agent and is not indicated for the treatment of hyperlipidemia, in controlled clinical trials[6] it caused a slight, sustained decrease in total cholesterol without reducing the HDL fraction or altering serum triglycerides.

At the same time, Wytensin lowered blood pressure as effectively as hydrochlorothiazide, propranolol, clonidine or methyldopa. Drowsiness and/or dry mouth, the most frequent side effects noted with Wytensin, usually diminish or disappear over time. In fact, in double-blind studies to date, discontinuance of therapy for all side effects occurred in about 13% of patients.



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Antihypertensive therapy that does not increase cholesterol

See important information on following page.

References: 1. Glueck CJ: Remarks in the symposium, *Blood Pressure, Cholesterol and Coronary Heart Disease*, Washington, D.C., March 31, 1985. 2. *The Framingham Study, An epidemiological investigation of cardiovascular disease*, Section 28, U.S. Dept. of Health, Education, and Welfare. 3. National Institutes of Health Consensus Development Conference Statement, 1984: Vol 5, No 7, p 4. 4. Chobanian AV: The influence of hypertension and other hemodynamic factors in atherogenesis. *Progress in Cardiovascular Diseases, XXVI* (3): 177, Nov/Dec, 1983. 5. Castelli WP: Remarks in the symposium, *Blood Pressure, Cholesterol and Coronary Heart Disease*, Washington, D.C., March 31, 1985. 6. Data on file, Wyeth Laboratories.

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Antihypertensive therapy that does not increase cholesterol

Brief Summary

Before prescribing, consult the complete package circular.

Indications and Usage: Treatment of hypertension, alone or in combination with a thiazide diuretic.

Contraindication: Known sensitivity to the drug.

Precautions: 1. Sedation. Causes sedation or drowsiness in a large fraction of patients. When used with centrally active depressants, e.g., phenothiazines, barbiturates and benzodiazepines, consider potential for additive sedative effects. 2. Patients with vascular insufficiency. Like other antihypertensives use with caution in severe coronary insufficiency, recent myocardial infarction, cerebrovascular disease, or severe hepatic or renal failure. 3. Rebound. Sudden cessation of therapy with central alpha agonists like **Wytensin** may rarely result in "overshoot" hypertension and more commonly produces increase in serum catecholamines and subjective symptomatology.

INFORMATION FOR PATIENTS. Advise patients on **Wytensin** to exercise caution when operating dangerous machinery or motor vehicles until it is determined they do not become drowsy or dizzy. Warn patients that tolerance for alcohol and other CNS depressants may be diminished. Advise patients not to discontinue therapy abruptly.

LAB TESTS. In clinical trials, no clinically significant lab test abnormalities were identified during acute or chronic therapy. Tests included CBC, urinalysis, electrolytes, SGOT, bilirubin, alkaline phosphatase, uric acid, BUN, creatinine, glucose, calcium, phosphorus, total protein, and Coombs' test. During long-term use there was small decrease in serum cholesterol and total triglycerides without change in high-density lipoprotein fraction. In rare instances occasional nonprogressive increase in liver enzymes was observed, but no clinical evidence of hepatic disease.

DRUG INTERACTIONS. **Wytensin** was not demonstrated to cause drug interactions when given with other drugs, e.g., digitalis, diuretics, analgesics, anxiolytics, and antiinflammatory or antiinfective agents, in clinical trials. However, potential for increased sedation when given concomitantly with CNS depressants should be noted.

DRUG/LAB TEST INTERACTIONS. No lab test abnormalities were identified with **Wytensin** use.

CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY. No evidence of carcinogenic potential emerged in rats during a two-year oral study with **Wytensin** at up to 9.5 mg/kg/day, i.e., about 10 times maximum recommended human dose. In the Salmonella microsome mutagenicity (Ames) test system, **Wytensin** at 200-500 mcg per plate or at 30-50 mcg/ml in suspension gave dose-related increases in number of mutants in one (TA 1537) of five *Salmonella typhimurium* strains with or without inclusion of rat liver microsomes. No mutagenic activity was seen at doses up to those which inhibit growth in the eukaryotic microorganism, *Schizosaccharomyces pombe*, or in Chinese hamster ovary cells at doses up to those lethal to the cells in culture. In another eukaryotic system, *Saccharomyces cerevisiae*, **Wytensin** produced no activity in an assay measuring induction of repairable DNA damage. Reproductive studies showed a decreased pregnancy rate in rats given high oral doses (9.6 mg/kg), suggesting impairment of fertility. Fertility of treated males (9.6 mg/kg) may also have been affected, as suggested by decreased pregnancy rate of mates, even though females received drug only during last third of pregnancy.

PREGNANCY. Pregnancy Category C. WYTENSIN® MAY HAVE ADVERSE EFFECTS ON FETUS WHEN ADMINISTERED TO PREGNANT WOMEN. A teratology study in mice indicated possible increase in skeletal abnormalities when **Wytensin** is given orally at doses 5 to 6 times maximum recommended human dose of 1.0 mg/kg. These abnormalities, principally costal and vertebral, were not noted in similar studies in rats and rabbits. However, increased fetal loss has been observed after oral **Wytensin** given to pregnant rats (14 mg/kg) and rabbits (20 mg/kg). Reproductive studies in rats have shown slightly decreased live-birth indices, decreased fetal survival rate, and decreased pup body weight at oral doses of 6.4 and 9.6 mg/kg. There are no adequate, well-controlled studies in pregnant women. **Wytensin** should be used during pregnancy only if potential benefit justifies potential risk to fetus.

NURSING MOTHERS. Because no information is available on **Wytensin** excretion in human milk, it should not be given to nursing mothers.

PEDIATRIC USE. Safety and effectiveness in children less than 12 years of age have not been demonstrated; use in this age group cannot be recommended.

Adverse Reactions: Incidence of adverse effects was ascertained from controlled clinical studies in U.S. and is based on data from 859 patients on **Wytensin** for up to 3 years. There is some evidence that side effects are dose related. Following table shows incidence of adverse effects in at least 5% of patients in study comparing **Wytensin** to placebo, at starting dose of 8 mg b.i.d.

Adverse Effect	Placebo (%) n = 102	**Wytensin** (%) n = 109
Dry mouth	7	28
Drowsiness or sedation	12	39
Dizziness	7	17
Weakness	7	10
Headache	6	5

In other controlled clinical trials at starting dose of 16 mg/day in 476 patients, incidence of dry mouth was slightly higher (38%) and dizziness was slightly lower (12%), but incidence of most frequent adverse effects was similar to placebo-controlled trial. Although these side effects were not serious, they led to discontinuation of treatment about 15% of the time. In more recent studies using an initial dose of 8 mg/day in 274 patients, incidence of drowsiness or sedation was lower, about 20%. Other adverse effects reported during clinical trials but not clearly distinguishable from placebo effects and occurring with frequency of 3% or less: Cardiovascular—chest pain, edema, arrhythmias, palpitations. Gastrointestinal—nausea, epigastric pain, diarrhea, vomiting, constipation, abdominal discomfort. Central nervous system—anxiety, ataxia, depression, sleep disturbances. ENT disorders—nasal congestion. Eye disorders—blurring of vision. Musculoskeletal—aches in extremities, muscle aches. Respiratory—dyspnea. Dermatologic—rash, pruritus. Urogenital—urinary frequency, disturbances of sexual function. Other—gynecomastia, taste disorders.

Drug Abuse and Dependence: No dependence or abuse has been reported.

Overdosage: Accidental ingestion caused hypotension, somnolence, lethargy, irritability, miosis, and bradycardia in two children aged one and three years. Gastric lavage and pressor substances, fluids, and oral activated charcoal resulted in complete and uneventful recovery within 12 hours in both. Since experience with accidental overdosage is limited, suggested treatment is mainly supportive while drug is being eliminated and until patient is no longer symptomatic. Vital signs and fluid balance should be carefully monitored. Adequate airway should be maintained and, if indicated, assisted respiration instituted. No data are available on **Wytensin** dialyzability.

Dosage and Administration: Individualize dosage. A starting dose of 4 mg b.i.d. is recommended, whether used alone or with a thiazide diuretic. Dosage may be increased in increments of 4 to 8 mg/day every one to two weeks, depending on response. Maximum dose studied has been 32 mg b.i.d., but doses this high are rarely needed.

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Newsletter

RHODE ISLAND MEDICAL SOCIETY
June 1986

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HOUSE CONSIDERS MEDICAL RECORDS BILL

Then RIMS President Doctor Herbert Rakatansky and Providence psychiatrist Doctor Robert J. Westlake testified April 29 before the House Judiciary Committee against a bill which would permit unlimited patient access to medical records. Pointing out that the bill would hamper the efforts of physicians to provide quality medical care, Doctors Rakatansky and Westlake told the committee that doctors willingly forward medical records to other physicians and discuss diagnoses, medications, and treatment with their patients. Continuity and quality of care and effective communication between physician and patient are of "overriding importance," the RIMS representatives said.

In another appearance before the House Judiciary Committee, Doctor Michael Ingall testified in favor of S 2682 which would protect the confidentiality of communications between patients and their physicians. The measure is necessary in light of a recent Rhode Island Supreme Court decision striking down the legal process section of the Health Care Information Act. Although another bill on the same subject has been introduced by Representative Maurice Caron, the Society said that S 2682 has a better chance of surviving a constitutional challenge.

Several other bills of interest to physicians are pending before the General Assembly:

- H 7756 (Carcieri) would prohibit smoking in the workplace unless an accomodation can be reached betwen smokers and non-smokers. In testimony before the House Committee on Health, Education, and Welfare, the Society praised the bill, saying that it immediately extends to non-smokers a measure of protection from the health hazards of secondary or "passive" smoking. Earlier this year, John C. Topping of the federal Environmental Protection Agency summed up the evidence linking passive smoke to disease, concluding that "strong steps to cut down involuntary exposure to cigarette smoke" appear warranted.

- Three bills have been introduced which would require physicians to accept assignment of benefits as payment in full for all Medicare beneficiaries. H 7982 and H 8102, introduced by Representative Francis Sherman, would require physicians and osteopaths to accept assignment as a condition of licensure. Another bill, also introduced by Sherman, would define balance billing under Medicare as "unprofessional conduct."

  In a strongly worded statement before the House HEW Committee, Doctor Herbert Rakatansky testified that these bills would violate federal Medicare regulations. When Title XVIII passed in 1965, the nation's physicians were told that assignment, ie, whether they agreed to accept Medicare as payment in full, would be an individual option to be determined on a per case basis. None of the bills would eliminate the co-payment and deductibles that are required by Medicare statute. Because patients would still have to meet the deductible and pay the 20 per cent co-payment for their physician visits, they would still face out-of-pocket expenses. Moreover, Doctor Rakatansky told the committee, the primary intent of licensure is to protect the public from unqualified practitioners. These standards would be weakened considerably if an extraneous factor, such as whether or not a physician accepts Medicare assignment, were included as a condition of licensure. The constitutionality of a similar law in Massachusetts which links Medicare assignment with licensure is being

contested.

- H 7724 (Carcieri) would create a durable power of attorney for health care purposes. In testimony before the Senate Judiciary and House HEW Committees, Doctor Hugo Taussig testified that the bill would provide "individuals, their families, and their physicians with peace of mind in knowing that the patient-doctor dialogue can continue by proxy when the principal is no longer competent to give or refuse informed consent to medical treatment." The Society also supported two bills which would provide a mechanism for establishing rights of the terminally ill, including the decision to have life-sustaining measures withheld or withdrawn.

- H 8049 (Gorham) would provide for the limited release of drug and alcoholism patient records. The Society opposed the bill on the grounds that it would jeopardize the confidentiality of medical information for a class of patients.

MALPRACTICE PROPOSAL BOGGED DOWN

As a result of the Bevilacqua impeachment proceedings, the House Judiciary Committee has yet to act on the omnibus malpractice proposal developed by the Legislative Commission on Medical Malpractice to alleviate the malpractice crisis. Nearly two-thirds of the recommendations address the Board of Medical Review, the state disciplinary agency for Rhode Island physicians.

Calling the Board a "miserable failure in policing the performance of Rhode Island physicians," Commission chairman Michael Forte (D, Tiverton) called for a new Board of Medical Licensure and Discipline which would have combined licensure and disciplinary functions. Although the new board would operate under the aegis of the Rhode Island Department of Health, the Commission recommended that it be autonomous in funding and professional decision-making. The board would be given new powers and funding to investigate complaints and malpractice settlements or awards against physicians. The new board would be financed by an annual assessment of up to $300 for physicians.

A similar bill introduced at the request of Governor Edward D. DiPrete has died on the Senate side although a companion version is still under consideration by the House Judiciary Committee. The Rhode Island Medical Society has vigorously objected to several provisions in the Di Prete bill which would have required physicians to incriminate themselves. Another provision would have permitted, rather than mandated, the governor to seek advice from the Society concerning appointments to the Board. A third objectionable clause would have allowed the Director of Health rather than the Board to appoint staff and legal counsel.

On May 17 the Providence Journal called for enactment of the DiPrete proposal, claiming that the omnibus package would do "little to disturb the status quo" in disciplining physicians. In his reply to the editorial, then RIMS President Doctor Herbert Rakatansky said that the position of the Rhode Island Medical Society was portrayed "inaccurately and unfairly." Citing efforts by the Society to identify and rehabilitate incompetent and impaired physicians, Doctor Rakatansky said the Society supported a "strong and effective medical disciplinary board with an appropriate system of checks and balances."

Other important reforms in the omnibus package include:

- Prejudgment interest would accrue from the date a suit is filed or formal notification of a suit is given rather than from the date of the alleged incident.

- Expert witnesses would be board certified in the appropriate specialty.

- Plaintiffs filing frivolous suits would be responsible for the defendant's legal expenses.

MALPRACTICE PROPOSAL (continued)

- Periodic payments for awards greater than $100,000 would be considered.
- The collateral source rule would be amended to preclude duplicate payments.
- Cases with a potential for substantial settlements would be placed on an accelerated court schedule.

Doctor Rakatansky emphasized that the bill provides only a starting point for significant tort reform. The Commission notably failed to act regarding caps on awards for pain and suffering or limits on attorneys' contingency fees. The Society and the Medical Liability Coalition had recommended a $250,000 cap on awards for non-economic losses and that contingency fees be limited on a sliding scale with ten per cent of all awards greater than $200,000.

JUA TO ADOPT MERIT-RATING MECHANISM

The Joint Underwriting Association should seek the guidance of the Society in developing its proposed merit-rating system, then RIMS President Doctor Herbert Rakatansky recently told the JUA Board of Directors. In 1985 the Department of Business Regulation ordered the JUA to develop a means of merit-rating physicians so that physicians with a higher level of settlements would pay higher premiums.

To work well, Doctor Rakatansky said, merit-rating must contribute to the financial stability of the JUA in two ways: by encouraging physicians whose loss experience is excessive to change their behavior and by generating additional premium income toward meeting underwriting losses. Emphasizing that the surcharge mechanism must "measure and reflect physician performance with reasonable accuracy," Doctor Rakatansky cited three principles that should be observed in the surcharge process. First, any system of surcharing physicians must be prospective in nature. A retrospective system would subvert an essential purpose of experience rating, that of "rewarding those whose past experience has led to a change in behavior." Second, any rating system should be related to fault as adjudicated by peer review. Moreover, points should be assessed for actual claims settled rather than claims filed.

Finally, to avoid the danger of a surcharge triggered by settlement of a nuisance suit, the JUA should establish a numerical threshold below which no accumulated dollar amount would result in a penalty. Such a provision, Doctor Rakatansky concluded, would help insure that the surcharge mechanism is linked rationally and realistically to physician performance.

PHYSICIAN UNION MEETS

More than 70 physicians attended a May 20 meeting organized by the Physicians & Surgeons of Rhode Island, according to a recent report in the Providence Journal. The group has held a series of membership recruitment meetings since its founding last December.

Featured speakers included Doctor Bruce Abbott, secretary of the Physicians & Surgeons Association of Massachusetts, who was quoted as saying, "They're slick," referring to health insurance organizations such as Blue Cross and Blue Shield and health maintenance organizations such as Rhode Island Group Health Association and Ocean State Physicians Health Plan. "They use lobbyists, they use advertisements, they know people in government," he said.

What doctors need, Doctor Abbott continued, is a pool of professional negotiators to scrutinize their HMO or Blue Cross contracts to make certain that the terms are fair. They need the power of a group since alone they are no match for an insurance company with as dominant a position in the market as Blue Cross and Blue Shield of Rhode Island.

Doctor Robert C. Hayes, president of the Rhode Island affiliate, told the Journal that the union's dues-paying membership has grown to approximately 170 practicing physicians in recent months.

The group hopes to attract 1,600 members, which represents most of the active physicians in Rhode Island.

PRACTICE MANAGEMENT QUESTION OF THE MONTH:

MEASURING AND IMPROVING PATIENT SATISFACTION

Nearly two thirds of the patients in the United States have changed physicians because they were displeased with their doctors or office staff. Since many patients would rather change physicians than express their dissatisfaction, it may take some hard work to obtain a valid indication of patient satisfaction. Several techniques can be employed to determine whether patients are pleased with the services provided by you and your staff.

The most popular tool for getting patient input is a patient survey, which can be completed in the office or mailed periodically to selected patients. Most practice management consultants recommend that physicians conduct a mail survey at least every other year, if not annually. Your mailing list should be comprised of patients you have seen during the past several months, including those seen more than once. It may also be informative to send the survey to some patients who have left your practice; their responses could help pinpoint problems within the office.

The questionnaire should be accompanied by a letter explaining that the survey will help you and your staff determine how to serve patients better. The number of surveys sent depends on the size of the practice, your budget, your objectives for conducting the survey, and the amount of time for tabulating the results. Enclosing a stamped, self-addressed return envelope will improve the response rate. The survey should be anonymous.

The following pointers may be helpful in designing your survey:

Include no more than 15 to 20 questions. Some practices ask for details such as whether a patient is new or established, the referral source, and demographic information. These questions should be included only if you plan to evaluate and use the responses.

Make it simple for the patient to respond. Popular formats include "yes/no" questions, having patients agree or disagree with statements, and rating various practice characteristics from excellent to poor. The last approach is helpful for indicating various levels of satisfaction.

Limit open-ended questions. Such questions as "How many days passed between the time you called the office and your appointment?" and "How long did you have to wait to see the doctor after your scheduled appointment?" are good examples. The end of the survey should provide patients with an opportunity to make additional suggestions for improving services.

Avoid qualifiers. Try not to use words like "usually" or "often" in the survey since patients will differ in their interpretation of such terms and might be discouraged from identifying an occasional exception to good performance.

Questions about the following subjects are included in most comprehensive patient surveys: the courtesy and knowledge of staff, the amount of waiting time involved, the explanation of medical problems and recommended treatment, the amount of interest shown by the physician and office staff, and satisfaction with fees.

Rhode Island Medical Journal

June 1986
Volume 69, Number 6

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Rhode Island Medical Journal is owned and published by the Rhode Island Medical Society, 106 Francis Street, Providence, Rhode Island 02903, Ph: 401-331-3207. Single copies $2.00 — Subscriptions $15.00 per year (members of the Rhode Island Medical Society — $5.00 annually). Published articles represent opinions of the authors and do not necessarily reflect the official policy of the Rhode Island Medical Society unless clearly specified. Advertisements do not imply sponsorship or endorsement by the Rhode Island Medical Society. Second class postage paid at Providence, Rhode Island and at additional mailing offices. **ISSN 0363-7913**

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COVER:

Food faddism is a multi-billion dollar industry and, according to the Food and Drug Administration, is the most widespread form of quackery in the United States. For more information, see page 263.

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EDITORIAL

Food Fads

Published elsewhere in this issue of the *Journal* is a review of the pitfalls and dangers of screwball diets. These dietary anomalies are in truth a form of quackery. It is fitting that we take cognizance of the attendant dangers in accordance with a long tradition of organized medicine in combatting quackery.

The Rhode Island Medical Society, founded in 1812, has as one of its objectives the exposure of quackery. An early observer[1] gave as the role of the Society "to find out if it can be done, what diet, and what habits of living are best calculated to keep the soul and body together," and further, "to arrest the progress of quackery, that hideous monster, whose head like the hydra's, has hitherto multiplied by amputation; whose liver like Prometheus' has grown as fast as it was devowed; and whose strength like Anteus' has increased under subjugation; a monster which has navigated every sea; mingled its breath with every breeze; reared its head in every clime; and since the days of Hippocrates been traversing the Earth and peopling it with corpes."

The *Boston Medical and Surgical Journal* in 1838 published a brief report from Rhode Island of two cases with dire outcome as a result of treatment by quacks.[2] From the very earliest days, the American Medical Association, founded in 1847, prosecuted a war on quackery. A resolution was introduced at its first session condemning the practice of allowing almost wholly ignorant persons to engage in healing pursuits.

According to Morris Fishbein, food faddism goes back to Egyptian times. In *Fads and Quackery in Healing*, he wrote in 1932: "Of all the people of the world, Americans are most cursed with faddists; of all of the faddists that occupy our attention the food faddists are most eccentric and most comical. We have those who believe that the eating of more white bread, more whole wheat bread, more fruit, or more raisins is necessary to healthful living.

"We are admonished at every turn to eat more of this or of that, or to confine ourselves wholly to some peculiar diet. We have those who oppose acids and those who oppose alkalines. The vegetarians who attack undue evils to the eating of meat base their conclusions on the fact that apes live on nuts, fruits, and cereals. Since most faddists are unscientific anyway, they are certainly inconsistent. The vegetarians say that animals living on vegetables are strong and tractable, while the meat-eating animals are ferocious. Who, however, would care to argue that the mind of man is governed by what he eats?"[4]

More than sixty years ago, Fishbein clearly identified food faddism with quackery. The recent spate of diet books raises serious questions about the ethics of the large publishers, the first amendment not withstanding, and of the food conglomerates who tout "all natural" foods. Are the FDA and the ICC serving the public well by standing idly by?

Seebert J. Goldowsky, MD

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PRESIDENT'S PAGE

A Reassessment of Priorities

The Rhode Island Medical Society has been undergoing change. We have moved progressively from a posture of reacting to events to one of taking charge and becoming more vocal, visible, and concerned. We have spoken out about the changes occurring in medicine and how they have had an impact on our patients' welfare and ultimately on the quality and cost of health care. The Society's position on issues has been increasingly recognized by both the public and government as that of the large majority of all Rhode Island physicians.

This change in the Society's role has been emphasized as the medical liability insurance situation in the state has reached crisis proportions. The Society's leadership has played an active role in the shaping of policy and focusing public awareness. Assisted by outside public relations counsel and our lobbyists, we have concentrated on gaining support for tort reform. Our efforts have been only partially successful, a reform bill having been passed in the Rhode Island Senate and now being considered by the House.

Our job is not complete. We have not achieved all that was necessary to resolve the medical liability insurance crisis. Most importantly, caps on pain and suffering and on attorneys' contingency fees are not included in the legislative package. We must maintain our militant posture to achieve this needed tort reform. Even more importantly, we must strive vigorously to have a voice in future changes that will affect the practice of medicine in the years ahead.

The resources of the Rhode Island Medical Society in the coming year must be increasingly applied to public relations and legislative affairs. Success in one is directly linked to success in the other. As for public relations, the public image of physicians must be enhanced. We must seek



Peter D. T. Clarisse, MD

to repair a sometimes sullied image by fostering a greater understanding of the medical professional through increased visibility and active involvement in the community as well as by constant attention to the quality of care. A successful public relations effort and a firm commitment to excellence in medical practice are essential to success in the legislative arena.

Regarding legislative affairs, opportunities to testify at committee hearings, speak to legislators, and publicly express positions on all health-related bills must be vigorously sought. It is the responsibility of all of our members to assist the General Assembly and share with them the view-

points of physicians and the health care community on proposed legislation. Without such professional involvement, legislators do not have the necessary background to make informed decisions.

For the society to project such community leadership is not easy. It requires both commitment on the part of the membership and the necessary resources. Available resources are limited. We are faced with the need of increasing our finances, rearranging our priorities, or both.

As president of the Society, I am committed to enhancing our financial base. Our investments must be managed wisely for the greatest return. I am also committed to reassessing with the assistance of the Long-Range Planning Committee the priorities of the Society. We will attempt to eliminate unnecessary expenses to redirect the Society toward the goals and priorities of the Long-Range Planning Committee. I am further committed to enhancing the financial base of the Society through aggressive dues collection and a broadening of the membership base to include all eligible physicians. Where medical issues arise, the authorities and the legislature address not the specialty societies, but the Rhode Island Medical Society. Those who for years have remained outside organized medicine have in effect had a free ride. We must make them see the light. The Society is underfunded for what needs to be accomplished. As it speaks for all physicians in the state, it is critically important that it have the support and participation of all physicians.

RIMS needs your support. The Society must have sufficient funding if it is to represent the state's physicians adequately. Otherwise it will be unable to sustain the quality of medical care which our patients deserve.

I ask for your help. Please contact your colleagues. Encourage them to support this organization and become an active participant in deciding the future of medicine. ■

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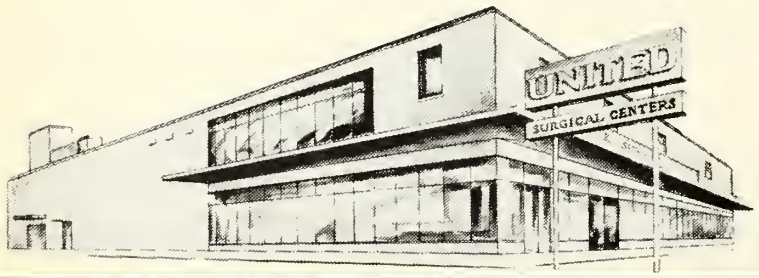
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Nutrition Misinformation: How to Protect Your Patients

Physicians Have Obligation to Alert Patients to Potential Dangers

Anita B. Lasswell, MS, RD
Tricia Leddy, MS, RD

Health quackery, including nutrition quackery, is on the rise. Congressman Claude Pepper (D, Florida) and his subcommittee published extensive testimony from a 1985 hearing in Washington.[1] One of the main points of the hearing was that although older Americans are especially susceptible to health fraud, no one is immune. In his 1981 presidential address to the American Society for Clinical Nutrition, Doctor Victor Herbert suggested that questionable nutrition information could possibly overwhelm nutrition science.[2] Some have suggested that this already has happened.[3]

Nutrition misinformation is not new. Magical properties have been attributed to certain foods and nutrients since earliest recorded history.[4] Nutrition ignorance and misinformation are widespread in our society.[5-8] Many health professionals and other leaders lack scientific nutrition information since nutrition course requirements for baccalaureate and graduate training vary widely.[9-13] Some politicians actively pursue legislation supporting nutrition misinformation and seek to exempt substances marketed as food supplements from regulation by the Food and Drug Administration (FDA). The Federal Trade Commission declared the terms "health foods," "organic foods," and "natural foods" deceptive, misleading, and undefinable, but no longer attempts to regulate their use in advertising.[14] *Consumer Reports* recently published an article confirming that some reputable pharmaceutical companies and drugstores promote unnecessary nutrition supplementation and sell more vitamin/mineral supplements than do health food stores.[15] Diploma mills across the country operate openly, awarding to "graduates" nutrition credentials such as "certified nutritionist" or "dietologist."[16, 17]

Such abuses probably would not continue if the public and health professionals were well-informed and held sound beliefs on nutrition. Nutrition quackery is not only a problem for nutrition science and technology, but also a behavioral problem that includes culture, religion, magical thinking, and the symbolism of certain foods. While not all food and nutrition misinformation is harmful, enough harm has been documented by individuals following spurious advice to warrant concern.[2]

Food faddism is a multi-billion dollar industry and, according to the FDA, is the most widespread form of health quackery in the US. The commissioner of the New York City Department of Consumer Affairs published an investigative report concluding that products sold in New York City health food stores were not only more expensive than identical products found in conventional markets, but included a vast array of pseudo-vitamins, food supplements possibly contaminated with arsenic and lead, diet aids unproven in safety and efficacy, and "organically grown" foods that contain pesticide residues.[18]

We shall discuss briefly some common types of products promoted by purveyors of nutrition misinformation. More thorough evaluations of these products are available.[19-24]

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Products Used for Chronic Diseases

Aloe Vera: Claims have appeared for this succulent plant's use in treating tuberculosis, gout, hypertension, arthritis, and emphysema. External use of the plant appears safe but the dried latex or fluid from the leaves is a severe cathartic. No toxic reactions have been reported, but individuals using it should be cautious, as quality control of the extract may vary.

Garlic: Promoted for use for hay fever, arthritis, sleep disorders, lung problems, and sinus infections, it also is reported to retard aging and prevent cancer and heart disease. Garlic taken in doses recommended for these ailments should be considered a pharmacologic agent, as these doses far exceed common dietary intakes.

Gerovital H-3: Sold as an anti-aging substance, Gerovital H-3 consists of mostly procaine hydrochloride. Controlled, double-blind studies have failed to demonstrate any benefit.

Nucleic Acids: Nucleic acids have been promoted as an anti-aging factor and as a cure for degenerative diseases such as diabetes, atherosclerosis, and senility. Nucleic acids when taken orally are digested in the gastrointestinal tract and are not absorbed intact. Because they can raise serum uric acid levels, high intakes should be avoided by persons predisposed to gout and uric acid urolithiasis.

Lysine: This essential amino acid is claimed to be effective for cold sores or fever blisters caused by the herpes simplex I virus. Studies have been inconclusive regarding its use. Caution should be exercised when the substance is taken in large doses. Because of the competitive nature of absorption of amino acids for binding sites, it could lead to amino acid imbalance in the body.

Products Used as Dietary Supplements

Vitamins

Niacin: Megadoses of niacin or nicotinic acid have been touted as a treatment for schizophrenia in "orthomolecular psychiatry" circles without conclusive evidence. Large doses (3-6 g daily) of niacin are used in the treatment of hypercholesterolemia. These doses have been found to be effective, but are not without serious side effects such as liver damage, cardiac arrythmias, nausea, vomiting, diarrhea, hypotension, tachycardia, and fainting.[25]

Ascorbic acid: Supplements of vitamin C are currently very popular items in pharmacies and health food stores. Reports of its use as a treatment for colds, cancer, and atherosclerosis have been inconclusive, and no clear-cut evidence exists for its efficacy as a treatment for any disease except scurvy. Adverse effects of megadoses of ascorbic acid include tooth enamel erosion from chewable tablets, precipitation of oxalate renal calculi in susceptible individuals, diarrhea, abdominal cramps, interference with urine glucose tests and tests for occult blood in the stool, "rebound" scurvy in infants born of mothers taking large doses, and hemolytic anemia in individuals with glucose-6-phosphate dehydrogenase deficiency.[19]

Vitamin B_{12}: Used for many years as a placebo, other claims for vitamin B_{12} or cyanocobalamin include treatment of infectious hepatitis, poor appetite, aging, multiple sclerosis, and poor growth. Well-controlled studies show no benefit from vitamin B_{12} injections or oral supplements.[26, 27] There is no known toxicity of vitamin B_{12} when taken in large doses.

Vitamin A: Experimental studies of vitamin A analogs and B-carotene have shown interesting results in cancer prevention. Retinol, or vitamin A, is very toxic in large doses and can cause extensive liver damage, is teratogenic, and can cause increased intracranial pressure.[19]

Vitamin B_6: Pyridoxine is enjoying popularity as a supplement to treat hyperemesis gravidarum and premenstrual syndrome. A recent report in the *New England Journal of Medicine* showed that some women taking megadoses of vitamin B_6 for premenstrual syndrome experienced polyneuropathies that were sometimes irreversible.[28]

Vitamin E: Many extravagant claims have been made for vitamin E in the prevention, amelioration, or cure of a number of chronic diseases and problems from ulcer and diabetes to arthritis and balding. Vitamin E is also promoted as an aphrodisiac and as a salve used topically for burns, stretch marks, and scars on the skin. Claims such as these have arisen as a result of misinterpretation of or extrapolation from animal studies. Clinically, vitamin E is useful in the treatment of hemolytic anemia in premature infants and of intermittent claudication.[29] Reports of toxicity consist of vague complaints for the most part; however, some serious side effects in human subjects have been reported at doses exceeding 900 mg daily.

Minerals

Calcium: Dolomite and bone meal supplements as well as calcium carbonate antacids are widely touted as the best prevention for osteoporosis.

Bone meal is the ground powder of animal bones, while dolomite is basically ground limestone or chalk, a combination of magnesium and calcium carbonates. Bone meal has been found in some cases to be contaminated with lead. Dolomite and other forms of calcium carbonate may alter the acidity of stomach contents, thereby reducing absorption of other nutrients such as iron.

Selenium: Selenium is enjoying popularity as a mineral supplement that can cure cancer, heart disease, sexual dysfunction, arthritis, and skin and hair problems and slow aging and prevent poor eyesight. Like many of the other claims made for dietary supplements, these have emerged from misinterpretation of animal studies. Because of its function as a part of the glutathione peroxidase system to protect against oxidant damages, much interest has been shown in its possible involvement in cancer prevention. It has been shown to inhibit carcinogenesis in some animal studies, but no clinical trials have yet been completed.[19] Since some forms of selenium are toxic, patients must be warned about supplementation in doses over 200 mg daily.

Zinc: Zinc functions as a cofactor for regulating the activity of many zinc dependent enzymes involved in nutrient metabolism. Promoters of its use as a dietary supplement claim that when given in large doses it can improve athletic performance, cure baldness, and improve sex drive and virility. Again, claims such as these seem to be based on extrapolation of data from animal studies taken out of context. Even though zinc supplements are well tolerated and have a large margin of safety, prolonged oral ingestion may result in symptoms of toxicity, may interfere with copper metabolism, and may reduce high density lipoprotein cholesterol levels.[19]

Ergogenic Aids

"Energy food for natural vitality," "promotes mental alertness and energy," "amazing breakthrough improves athletic performance." Whether it be pill, powder, liquid, capsule, syrup, or granule, there is a multitude of products on the market which claim to boost energy.[30] Many athletes claim that one reason for their successful performance was the ingestion of a particular food or food supplement. This type of anecdotal testimony is not supported by scientific evidence.[31] Among various products promoted as ergogenic (energy-producing) aids are vitamin E, vitamin C, wheat germ, wheat germ oil, bee pollen, sunflower seeds, lecithin, honey, gelatin, phosphates, kelp, and brewer's yeast.[31] Studies in the early 1970s with vitamin E and vitamin C supplements confirmed that neither had ergogenic properties.[32,33] Recent claims that bee pollen can increase energy, strength, and stamina in competition are not supported by scientific evidence. Indeed, experts have concluded that pollen has no unique characteristics that work to supply more energy, despite one company's current $30 million sales of bee pollen products.[34]

The American Dietetic Association officially stated in 1980 that it does not recognize any unique ergogenic value of products.[31] The most practical advice for healthy patients wanting to increase their energy or boost athletic performance is regular exercise, healthy eating patterns, and adequate sleep.

Weight Loss Fads

Approximately 88 million Americans are considered overweight, and 40 million are considered clinically obese (20 per cent above ideal body weight).[35] The desire to lose weight has helped to spawn an industry in America with revenues estimated to be close to $10 billion. Dieters are easily tempted by the vast array of books, diets, drugs, liquids, candies, diet foods, and devices that promise to shed excess pounds quickly and without effort. Many are promoted as closely guarded secrets or "new discoveries."

Each season at least one diet book is high on the bestseller list.[37] A recent study of the nutritional adequacy of 11 currently popular diet books revealed that none provided 100 per cent of the US Recommended Dietary Allowances for the 13 vitamins and minerals studied.[38] The latest best-selling diet book is based upon a theory of digestion which has certainly never graced the pages of a medical text. Due to the exclusion of milk products, most people who follow its advice will be deficient in dietary calcium, which is of particular concern for those at risk for osteoporosis.

Over-the-counter drugs and supplements: The FDA has recently targeted weight loss gimmicks as part of a national public service campaign against health fraud.[39] Specific products deemed dangerous or ineffective by the FDA include phenylpropanoloamine (PPA), benzocaine, human chorionic gonadotropin, glucomanan, spirulina (derived from algae), starch blockers, cholecystokinin, and the amino acids arginine and ornithine.[37]

Ketogenic diets: Clark and Blackburn described the complications associated with low carbohydrate, high protein ketogenic diets as ketosis, cal-

cium depletion, dehydration, weakness, nausea, impaired renal function, vitamin/mineral deficiencies, and hyperuricemia.[40] Many storefront weight loss programs and published weight loss diets are based on a ketogenic diet plan.

Fasting: In addition to the complications associated with the ketogenic diet, fasting can result in negative nitrogen balance and loss of lean body mass. Adverse effects on heart, renal, and liver function have also been reported.[40]

Liquid meal replacements: Sours described 17 deaths associated with the use of very low calorie liquid protein regimens. The deaths appeared to be independent of the type of medical supervision received and biological quality of the protein product used.[41] The deaths were secondary to ventricular arrythmias following prolonged use of low calorie, high protein diet formulas. New variations contain higher quality protein and mineral and vitamin supplementation that the earlier products lacked.[43, 44] However, they are still considered dangerous; the FDA has attributed six deaths to the newer formulas, often sold in supermarkets, drugstores, and by "diet counselors" with no formal training in the health or nutrition fields.

A successful weight loss program should be based on a nutritionally adequate diet with a minimum of 1200 calories, with 50 per cent of the calories as carbohydrates, 15 to 20 per cent as protein, and 30 per cent as fat. Additionally, the program should strongly encourage exercise, incorporate behavior modification strategies, and provide frequent follow-up visits or group meetings for support.[42]

How to Spot a Purveyor of Nutrition Misinformation

An easy way to spot misinformation is to identify "tags" or features of fallacious claims. The more tags that can be applied to the claim, the less valid it becomes. Common tags found in claims are listed below:

Sales pitch: Many promoters of unsound nutrition information are salesmen first, utilizing sales techniques. They create a need and then show how their product will fill that need.

Magical thinking: The nostrum "if a little is good, more is better" and "if it sounds too good to be true, it probably is" apply here. Key words such as "cure," "miraculous," "amazing," "easy," "quick," and "painless" lure the gullible person. Even well-educated, intelligent individuals are not totally immune to having their sense of magic aroused.

Half truths: Many of the promoters' claims are taken out of context and extrapolated from animal research. A good example of a common half truth is the claim that certain vegetable oils and margarines have no cholesterol. The unsuspecting public does not know that plant products are naturally free of cholesterol.

Testimonials: This "tag" is the hallmark of many nutrition claims. If a celebrity, sports figure, or even an ordinary citizen reports benefits from a particular product, people tend to believe that it will work for them as well.

Scare tactics: Promoters of nutrition misinformation often try to frighten people with warnings of cancer, contaminated foods, malnutrition, and other health problems especially if their product is not regularly used. They offer protection from a host of ills that might befall any of us.

Amateur diagnosis: Some popular fad diet books on the market contain lists of symptoms that alert the reader and encourage him or her to self-diagnose a health problem. Of course, the diet offers a "cure" for all symptoms listed.

Persecution complex: Many purveyors of nutrition quackery claim to be victims of persecution by organized medicine, government agencies, and other established institutions.

Fake credentials: Nutrition is a subject that attracts many charlatans. Unfortunately, as already mentioned, many diploma mills operate openly, awarding worthless certificates and degrees to anyone who has paid a fee.

How Can Physicians Help Guard Against Nutrition Quackery?

Patients will often rely on the advice of their physicians to evaluate the safety and effectiveness of various gadgets, pills, or food supplements claimed to aid in weight loss, cure disease, or otherwise provide health benefits. Patients may be reluctant to discuss these self-prescribed regimens with their physicians; indeed, the physician must try to elicit this information from patients so that they can at least be monitored while following a weight loss regimen, or discouraged if safety is a concern.

Once again, the physician must be the "gatekeeper." The greatest help may be in listening to patients' concerns, watching for potentially dangerous products marketed locally, and providing this information to patients.[17] Successful strategies for working with patients include: understanding and respecting the patient's health

beliefs, eliciting information using a nonjudgmental approach about the specific product or fad diet, and finally, offering constructive suggestions for change.

For weight loss and other nutrition-related problems, a registered dietician will provide the patient with an individually planned, nutritionally adequate diet and follow-up as needed. Dietitians are available to patients in almost all hospitals on an outpatient basis, as well as in private practice, health centers, and other settings. A list of settings where dietitians provide nutrition counseling is available at no charge from the Office of Nutrition Services at the Rhode Island Department of Health (401/277-2309).

There are many resources ready to provide specific information on questionable products and to respond to complaints. Registered dietitians working in the hospital where a physician is affiliated are excellent resources for the physician for information on nutrition quackery.

The following organizations are also excellent resources:

For information:

Rhode Island Nutrition Hotline
Rhode Island Department of Health
75 Davis Street
Providence, Rhode Island 02908
800-624-2700 (9am-1pm)

National Council Against Health Fraud
PO Box 1276
Loma Linda, California 92354
714/796-3067

To file a complaint:

Food and Drug Administration
585 Commercial Street
Boston, Massachusetts 02109
617/223-5857

Better Business Bureau
270 Weybosset Street
Providence, Rhode Island 02903
401/272-9802

To file a complaint concerning a product sold or advertised by mail:

US Postal Service
Providence Post Office
24 Corliss Street
Providence, Rhode Island 02904
401/276-6930

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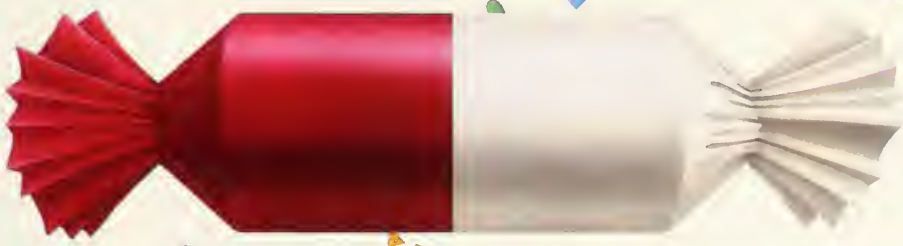
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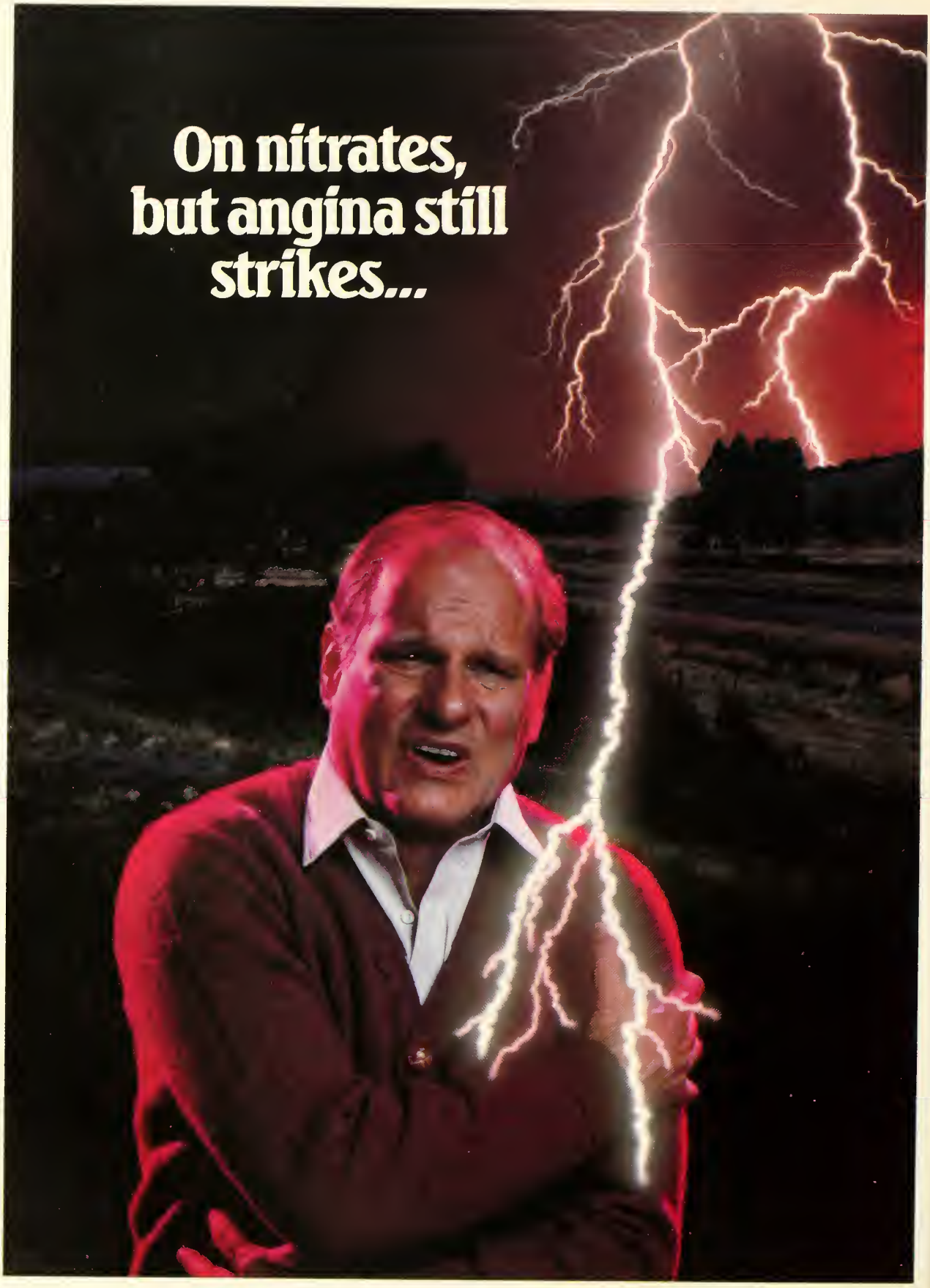
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Marked 1° or progressive 2° or 3° AV block requires a dosage reduction or, rarely, discontinuation and institution of appropriate therapy depending upon the clinical situation. Patients with hypertrophic cardiomyopathy (IHSS) received verapamil in doses up to 720 mg/day. It must be appreciated that this group of patients had a serious disease with a high mortality rate and that most were refractory or intolerant to propranolol. A variety of serious adverse effects were seen in this group of patients including sinus bradycardia, 2° AV block, sinus arrest, pulmonary edema and/or severe hypotension. Most adverse effects responded well to dose reduction and only rarely was verapamil discontinued. **Precautions:** ISOPTIN should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of excessive pharmacologic effects. Studies in a small number of patients suggest that concomitant use of ISOPTIN and beta blockers may be beneficial in patients with chronic stable angina. Combined therapy can also have adverse effects on cardiac function. Therefore, until further studies are completed, ISOPTIN should be used alone, if possible. If combined therapy is used, close surveillance of vital signs and clinical status should be carried out. Combined therapy with ISOPTIN and propranolol should usually be avoided in patients with AV conduction abnormalities and/or depressed left ventricular function. Chronic ISOPTIN treatment increases serum digoxin levels by 50% to 70% during the first week of therapy, which can result in digitalis toxicity. The digoxin dose should be reduced when ISOPTIN is given, and the patients should be carefully monitored to avoid over- or under-digitalization. ISOPTIN may have an additive effect on lowering blood pressure in patients receiving oral antihypertensive agents. Disopyramide should not be given within 48 hours before or 24 hours after ISOPTIN administration. Until further data are obtained, combined ISOPTIN and quinidine therapy in patients with hypertrophic cardiomyopathy should probably be avoided, since significant hypotension may result. Clinical experience with the concomitant use of ISOPTIN and short- and long-acting nitrates suggest beneficial interaction without undesirable drug interactions. Adequate animal carcinogenicity studies have not been performed. One study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. *Pregnancy Category C*: There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor and delivery only if clearly needed. It is not known whether verapamil is excreted in breast milk; therefore, nursing should be discontinued during ISOPTIN use. **Adverse Reactions:** Hypotension (2.9%), peripheral edema (1.7%), AV block: 3rd degree (0.8%), bradycardia: HR < 50/min (1.1%), CHF or pulmonary edema (0.9%), dizziness (3.6%), headache (1.8%), fatigue (1.1%), constipation (6.3%), nausea (1.6%), elevations of liver enzymes have been reported. (See *Warnings.*) The following reactions, reported in less than 0.5%, occurred under circumstances where a causal relationship is not certain: ecchymosis, bruising, gynecomastia, psychotic symptoms, confusion, paresthesia, insomnia, somnolence, equilibrium disorder, blurred vision, syncope, muscle cramp, shakiness, claudication, hair loss, macules, spotty menstruation. **How Supplied:** ISOPTIN (verapamil HCl) is supplied in round, scored, film-coated tablets containing either 80 mg or 120 mg of verapamil hydrochloride and embossed with "ISOPTIN 80" or "ISOPTIN 120" on one side and with "KNOLL" on the reverse side. Revised August, 1984 2385

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Certificate of Need: A Concept Whose Time Has Passed

The Competition of the Marketplace Should Be Allowed to Function without Governmental Interference

Joseph A. Chazan, MD

In 1967, the Rhode Island General Assembly, faced with rising and perceived uncontrolled health care costs, created a commission to investigate hospital room rates. The deliberations of this commission resulted in the creation of the certificate-of-need (CON) process. This program was designed to control that portion of health care costs attributable to hospital capital expenditures. However, in 1974 when the US Congress passed the National Health Planning and Resources Development Act, PL 93-641, which required each state in order to receive federal funds to establish a certificate-of-need program to control health care facility construction, renovation, and development, the Rhode Island legislature and the Department of Health took this opportunity to expand its authority under the certificate-of-need program. Since then, Rhode Island has had one of the most encompassing and restrictive programs in the nation. Several reports have suggested that the certificate-of-need mechanism was effective in controlling costs although the data were at best inconclusive.

At the present time changes in reimbursement incentives and a virtual revolution in the funding of health care suggests that the efficacy of the certificate-of-need process as a positive modifier of health care costs should be reexamined. The purpose of this review is to reevaluate Rhode Island's experience with the certificate-of-need process, to speculate as to its usefulness in the foreseeable future, and to suggest an alternative approach.

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CON Process from 1970 to 1979

During the decade of the seventies, published reports from the Rhode Island Department of Health suggested that the process was economically beneficial and promoted great savings. The data to support these conclusions were largely based, however, on experience during the early years of the decade. This early experience was characterized by a short review time and greater flexibility in conducting the review. During these early years, the costs for developing certificate-of-need applications were relatively insignificant since there was no application format, nor did it require applicants to file within a specific time frame. In addition, reviews routinely took less than 90 days, and inflation-related delay costs were held to a minimum.

The process was not without its problems, however, since the denial rates did not provide very good evidence of reducing costs. Furthermore, the process had no effect on system-wide planning and did nothing to prevent duplication or encourage economy. In fact, the very aspects of the program which contributed to the relative absence of process-related costs, ie, its informality and prompt response, also acted as a virtual bar to the development of any comprehensive plan for health care growth. The process was reactive and lacked a planning framework.

CON Process from 1980 to 1985

In 1978 the certificate-of-need process became more formalized, expanded, and strengthened, but this new approach did not necessarily im-

prove the impact on health care costs. At the present time, for hospitals there is only a single review cycle between 210 and 330 days, and for other health care facilities there are two cycles that can take up to 210 days to complete. The only relief from this inordinate delay is afforded by the prospect of expeditious review which is only granted under extraordinary circumstances.

Data obtained from the Rhode Island Department of Health for the period of 1980-1985 are presented in Tables 1-4 and reveal that the certificate-of-need process has done very little in terms of avoiding capital expenditure and duplication in the hospital sector. With few exceptions hospital proposals are approved whereas other health care facilities are subject to a significant denial rate.

Although hospital proposals appear to be modified and reduced in costs as a result of this process, this is more apparent than real. Applicants realize that in their initial request they have to "give something away," but still have enough left to get what they want. As a result, the so-called negotiation is a charade. The reviewers, in order to satisfy the federal government's need to document savings, demonstrate that they are in fact "reducing" the project and "saving" dollars. Thus, applicants who expect proposals to be revised downward during the review process inflate their original proposals to enable the state agency to claim savings. Although these savings are not "real," the delays imposed on the process are very real and are probably more than sufficient to offset any real savings. On the other hand, the advocates of certificate of need have pointed to the effect of the process in stemming the tide of construction and duplication of hospital beds. Unfortunately this argument is unsupportable by facts.

Table 1. Hospital Certificate of Need Experience 1980-1985

	Number	Capital Costs
Proposals approved	48	$122,323,000
Proposals denied	2.5	$ 3,150,000
Proposals delayed longer than six months*	13	$ 70,838,000

*Longest delay — Miriam Ambulatory Surgery — 29 months

Table 2. Denial Details Certificate of Need Hospital Experience 1980-1985

	Capital Costs
The Miriam Hospital — Chronic pain program	$ 150,000
The Miriam Hospital — Behavioral Medicine Unit	$3,000,000
Butler Hospital — Flexible increase in licensed bed capacity	none

The Next Few Years

Although the preceding evaluation could be variously interpreted, the future of certificate of need in light of changes in the health care system must be reexamined. The health care system has now changed dramatically with the advent of diagnosis-related groups, health maintenance organizations, preferred provider organizations, and other alternative delivery systems, and we are entering a period when only those institutions which effectively compete in the marketplace will and should survive. Efficiency and economy of scale, provision of unique services, and an innovative approach to the delivery of health care is mandated at all levels. In this setting, the certificate-of-need process represents a cumbersome, retrogressive approach to the reality of health care in the 1980s. As long as the entire cost of new programs are not passed on to third-party insurance companies or patients, creating new services or facilities should not be restricted. For example, the development of outpatient surgical centers, dialysis centers, and emergency rooms should not need to be approved under this process. Rather, they should be licensed in a fashion which assures quality of care. The source of capital and the financial arrangements should be of little concern to the Department of Health if these services can be provided in an efficient, cost-effective way and be reimbursed in a competitive fashion. It is fair to say that in the emergence of health maintenance organizations, the concerns of business and the overwhelming involvement of the federal government will assure that cost-effectiveness will be an important factor for successful programs. A continued policy of governmental control which is not keeping with national trends will do little to improve health care in Rhode Island or positively effect the cost of delivering this care.

A new approach to the handling of these matters may be useful. The Department of Health and the state legislature would benefit from re-evaluating their position and perhaps establishing one that does not require such strict regu-

Table 3. Other Health Care Facilities (1980-1985)

Proposals approved — 45 (32 nursing home bed reclassifications and small bed increases)
Proposals denied or withdrawn — 18
Proposals delayed more than 6 months — 6 (two delayed proposals are now beginning their second year of review)

Table 4. Denial Details — Other Health Care Facilities (1980-1985)

13 of 18 denials — proposals by proprietary facilities to establish alternatives to institutional care as follows:
2 home health agencies
2 nursing homes
2 surgery centers
1 mobile CT scanner operation
5 outpatient alcohol/drug abuse treatment centers
1 inpatient alcohol treatment center

lation and control. Everyone is interested in providing quality services at affordable cost. Since providers of these services are ever-increasingly aware of the cost implications of creating new facilities or programs, it is unlikely that reasonably prudent persons will expand, duplicate, or extend themselves beyond their fiscal means. Since virtually all hospital proposals are approved (Table 1), the applicants perhaps should be allowed to proceed with their expansions if they are not linked totally to reimbursable charges. If the program is to be linked to reimbursable charges, then some negotiation should take place. For example, a dollar figure for reimbursement should be agreed upon, and the total cost of the project could be determined by the hospital, ie, how much it will cost them. For free-standing facilities, the competition of the marketplace should be allowed to function without governmental interference or control except for licensure.

Rhode Island has consistently been at the bottom of the innovative ladder. While we benefit by avoiding the mistakes of others, we pay a high price in our acceptance of a medical package which is always five to ten years behind the leaders. This new approach may be productive, and it certainly is better than the status quo, which has not proved to be effective in the recent past and is far less likely to have a positive impact in the foreseeable future.



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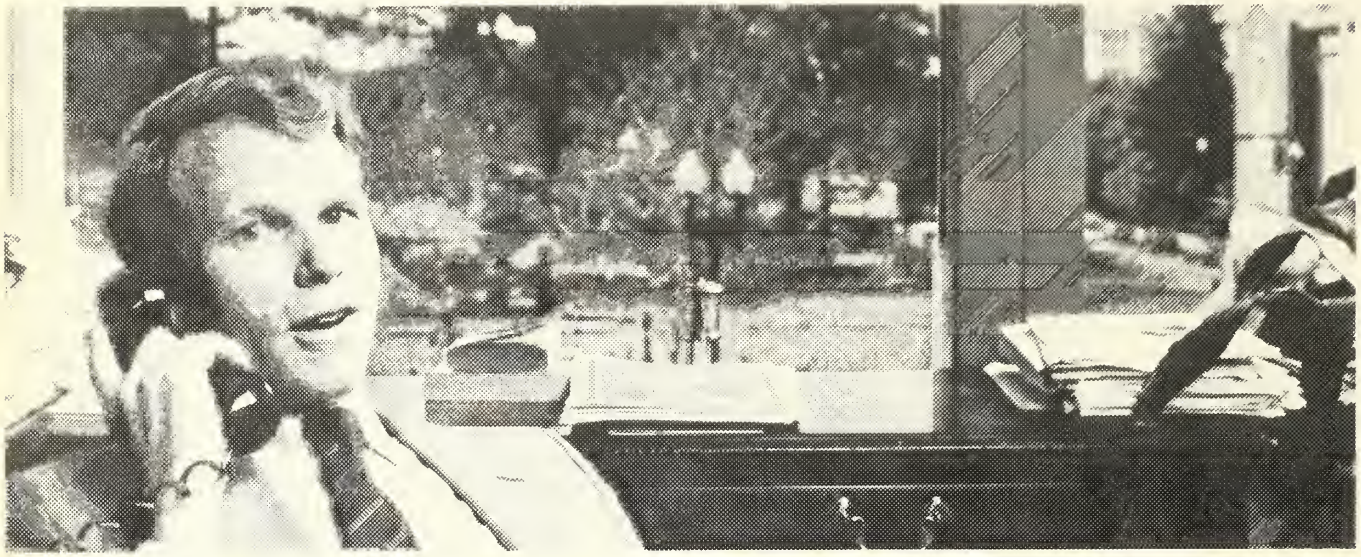
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Tropical Sprue and Multiple Myeloma

Chronic Immunocyte Stimulation May Have Led to Autonomous Proliferation of a Malignant Clone of Plasma Cells

Douglas S. Levine, MD
H. John Ree, MD
James P. Crowley, MD

Tropical sprue is one of many gastrointestinal entities that are characterized by small intestinal mucosal damage (villous flattening) and malabsorption, including gluten sensitive enteropathy (or celiac disease), infectious enteritides, immunodeficiency syndromes, malnutrition, and others.[1] The disease is endemic to various tropical regions and can affect visitors to these areas. The term "tropical malabsorption" or "tropical enteropathy" is applied to patients who may present with a wide spectrum of manifestations of malabsorption syndrome developing in the tropics, but the term "tropical sprue" applies to those patients with the most severe secondary effects in whom no etiology can be found.[2, 3] Patients with the latter affliction typically present with symptoms of diarrhea and weight loss, have stigmata of malnutrition, and have laboratory evidence of iron, folate, or vitamin B_{12} deficiency anemia, and impaired fat, vitamin B_{12}, and carbohydrate absorption. On jejunal biopsy, microscopic sections show flattened villi with mononuclear infiltrate. Therapy with folate replacement and tetracycline is usually effective.

The etiology of tropical sprue is unknown, but theories about possible nutritional deficiencies, transmissible infectious agents, or dietary or infectious toxins resulting from proximal small bowel bacterial overgrowth have been discussed.[3-6] The potential long-term malignant complications of this condition are unknown, which contrasts with the well-established relationship between celiac disease and carcinoma,[7-9] lymphoproliferative disease,[7, 10-14] immune deficiency states, and malignant diseases.[15-19] Accordingly, we thought it worthwhile to document the occurrence of myeloma in a patient with long-standing tropical sprue.

Case Report

A 57-year-old male from the Dominican Republic was admitted to the hospital with complaints of increasing generalized weakness and shortness of breath accompanied by symptoms of an upper respiratory tract infection. He was taking no medications. He described diarrheal bowel movements intermittently occurring for at least five years, including the two years he had been in the United States. During the years before his admission, he had lost 5-10 kg of weight. The patient had been diagnosed two years earlier as having multiple myeloma at another hospital. The cause of his diarrhea was not determined at that time although a Schilling's test was abnormal. He received five courses of monthly melphalan and prednisone, but he discontinued his treatment for obscure reasons nine months prior to admission to this hospital.

On physical examination the patient was thin, pale, and mildly tachypneic, with a congested cough. The lungs were clear. Cardiac examination revealed a S4 gallop without murmurs. The abdomen was distended without evidence of or-

This study was supported in part by NRSA AM-07113-09.

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ganomegaly, masses, or ascitic fluid. The rectal examination was normal, and the stool was negative for occult blood.The extremities revealed marked pitting ankle edema. Neurologic examination was normal. Nutritional assessment of this 56 kg, 165 cm tall male showed him to be 7.5 kg below his ideal body weight.

Laboratory studies included hematocrit 15.9 per cent, hemoglobin 4.9 gm per cent, MCV 135 μl, MCH 43 μμg, MCHC 31.3 per cent, white blood count 5700/μl (53 per cent segmented leukocytes, 45 per cent lymphocytes, 2 per cent monocytes), platelet count 75,000/μl, reticulocytes 3 per cent, peripheral blood smear (macrocytic erythrocytes and hypersegmentation of the segmented leukocytes); sodium 137, potassium 4.1, chlorine 109, HCO_3 25 (anion gap=3), and magnesium 0.9 mEq/l; blood urea nitrogen 11, creatinine 1.0, glucose 81, calcium 8.2, and phosphate 2.9 mg per cent; erythrocyte sedimentation rate 95 mm/hour; total protein 8.9 and albumin 2.4 mg per cent with large M-component in the gamma region; quantitative immunoglobulin levels IgG 5850, IgA 34 and IgM 54.4; urine electrophoresis showed free kappa light chains. Bone marrow biopsy and aspiration showed active hematopoiesis with megaloblastic features, reduced iron stores, and 50 per cent plasma cells. Malabsorption studies are shown in Table 1.

Upper gastrointestinal and small bowel follow-through radiographic study revealed delayed transit time and evidence of mucosal edema with thickening of mucosal folds throughout the small bowel. Jejunal biopsy revealed appreciable villous flattening with mucosal nonspecific chronic inflammation without other specific alterations. Amyloid was not present. Duodenal aspirate for bacterial culture and Giardia was unremarkable. Stool culture revealed normal flora and specimens were free of ova and parasites.

The clinical picture and laboratory studies suggested a diagnosis of tropical sprue in association with IgG kappa multiple myeloma, and the patient was given a therapeutic trial of parenteral vitamins B_{12} and potassium, folate 1 mg daily by mouth, and tetracycline 250 mg four times daily by mouth. The reticulocyte percentage rose to 33.4 per cent, hemoglobin to 8.5 gm per cent, and hematocrit to 27.8 per cent. The patient gained 5 kg over a 21-day period. Following the favorable response to therapy for tropical sprue, the patient was treated with a four-day course of melphalan, prednisone, and allopurinol. A repeat Schilling's test performed three months after treatment with tetracycline was normal.

Table 1. Malabsorption Studies of a Patient with IgG K Multiple Myeloma and Tropical Sprue

Determinations	Results	Normal Values
Prothrombin time	15.3	11.3 sec
Serum carotene	10.0	>75 mg/dl
Urinary indicans	246.0	<120 mg/dl
D-xylose absorption (5 hrs)	3.24	6.6±1.2 gm
Schilling test	6%	>7.5%
72-hour stool fat	37.6	2-5 g/24 hrs
Gastric pH	2.0	1.1-6.0

Table 2. Gastrointestinal Diseases Reported in Association with Multiple Myeloma

	Reference
A. Malabsorption syndrome:	
1. Infection	(See text)
2. Amyloidosis	(See text)
3. Plasmacytic infiltration	(See below)
4. Celiac disease	12,14
5. Idiopathic steatorrhea	22
B. Plasmacytic infiltrative disease:	
1. Solitary plasmacytoma	12
2. Nodular polyposis	23
3. Myelomatous polyposis	24
C. Coincident or antecedent gastrointestinal illness:	
1. Ulcerative colitis	25,26
2. Peptic ulcer disease	26
3. Cholecystisis, cholelithiasis	26
4. Chronic pancreatitis	26
5. Atrophic gastritis	26

Comment

Malabsorption in patients with multiple myeloma is reported rarely, but when it occurs it may be secondary to amyloidosis or infectious enteritides (eg, giardiasis), or more rarely plasmacytic infiltration of the small bowel with maintenance of mild blunting of the epithelial villous architecture,[20,21] celiac disease,[12,14] or, perhaps, other unknown causes.[22] Our patient demonstrated no findings to suggest any of these diagnoses. His malabsorption studies, small bowel biopsy, response to therapy with folate and tetracycline, and emigration from a region endemic for tropical sprue all supported this diagnosis. Gastrointestinal illness is seldom reported in association with multiple myeloma, and aside from malabsorption syndrome may include either plasma-

cytic infiltrative disease of alimentary tract mucosa or other coincident diseases (Table 2).

The relation between tropical sprue and multiple myeloma in our patient is speculative. The etiology and pathogenesis of plasma-cell dyscrasias[27, 28] based on animal models involves chronic stimulation of immunocytic lymphoid tissue as the initial carcinogenic factor. Transient paraproteinemias,[29] or a self-limited appearance and subsequent disappearance of monoclonal immunoglobulin protein occur in tropical sprue,[30] celiac disease,[31] acquired hypogammaglobulinemia,[29] and Wiskott-Aldrich syndrome.[29] These observations suggest continuing immuocyte stimulation with autonomous proliferation that could precede malignant change in lymphocytes or plasma cells.

A dysfunctional gastrointestinal tract may promote carcinogenesis in ways other than as a substrate on which immunocytes are chronically stimulated. Patients with secretory IgA deficiency have been documented to have excess serum antibodies to food and bacterial antigens[32] which suggests another plausible explanation of associated malignant disease: the potential ease of passage of oncogenic antigens or viruses through the permeable mucosa. Evidence for this hypothesis comes mainly through the study of other diseases, including inflammatory bowel disease, gastrointestinal allergy, celiac disease, toxigenic diarrhea, chronic active hepatitis, and autoimmune disease in which enhanced intestinal uptake of antigenic macromolecules via an altered mucosal barrier[33] may participate in the development of systemic disease.

The occurrence of multiple myeloma in a patient with tropical sprue adds support to the concept that malabsorption, perhaps with an associated inherited or induced dysfunctional immune system, may form the pathogenetic basis for the subsequent development of lymphoproliferative disease.

Summary

The clinical presentation and course of a 57-year-old man with tropical sprue and multiple myeloma is reported. The malabsorption syndrome antedated the development of myeloma. Since transient paraproteinemias have been observed in tropical sprue, the association of these two diseases may be related to prior chronic immunocyte stimulation with eventual autonomous proliferation of a malignant clone of plasma cells.

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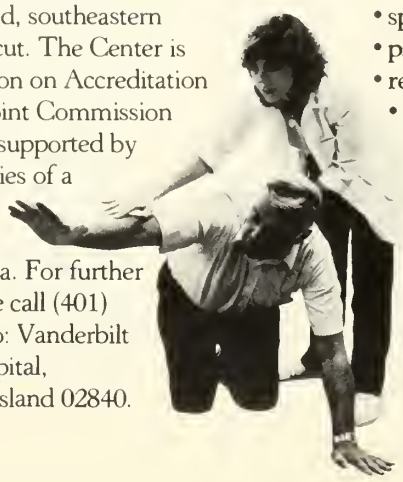


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The Role of the Family Practitioner

We Must Work Together to Shape a System of Excellence for the Benefit of All Americans

Senator Claiborne Pell

The very idea of the family physician is one that is generally associated with trust and respect. The current atmosphere of professional specialization is such that we have endless specialties in medicine, tax lawyers who specialize in capital gains, and football players who play nose tackle in third down situations. It is against this backdrop that we view our family physician, the general practitioner, as friend, confident, and healer.

We have many crises facing us today. The threat of nuclear war, domestic and international economic difficulties, and the increasing recreational abuse of narcotics by a frightening number of our people, to name a few. To most individuals, however, these problems are not of great significance unless that individual enjoys reasonably good health. One of the most astute remarks that Benjamin Disraeli ever made was that " . . . the health of the people is really the foundation upon which all their happiness and all their powers as a state depend." It is in this regard that the crisis in health care delivery deserves priority attention.

The cost of health care stands out as the single most inflationary factor in the American economy today. If indeed there is a season for everything and a time for every purpose under heaven, then now is the season and time for all Americans to deal with the cost of health care. The cost of medical care continues to rise at triple the increase in the consumer price index, which itself has a health care component. In 1982, the total bill for health care in the United States was $321 billion. That represents a levy of $1,400 on every man, woman, and child in America. Almost 15 cents of every federal tax dollar spent went to the health care industry, and the costs of health care are driving many states into a deficit. Health care is, of course, itself a big industry, one of the biggest. The United States channels ten per cent of our gross national product (GNP) into the health care industry, placing us third in the world in the percentage of GNP diverted for health care expenditures. In spite of this fact, we are ranked only fifteenth for men and eighth for women in terms of longevity.

We can and should take satisfaction in that progress has been made in assuring health care for our citizens in the last twenty years. There was no Medicare program when I first went to the Senate. I was a cosponsor of the bill that enacted the program. Also, I cosponsored legislation which led to the growth of health maintenance organizations and worked very hard to get the Rhode Island Group Health Association established. In addition, I initiated the capitation legislation that resulted in Brown's medical school. We have witnessed the spread of health care to underserved populations through community health centers and Medicaid-funded home health care programs. After 24 years of progress in making health care available, rising costs now threaten to make it less accessible.

In fact, Rhode Island could be the model health care state with its single medical district, its medical school and teaching hospitals, and its outreach community health centers.

There is no question that we are in the midst of a health care crisis. We all have contributed mightily, albeit most of the time with the best intentions, without forseeing the worst of the unintended effects. Health care costs have been largely hidden from the consumer in prepaid

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Senator Claiborne Pell serves the State of Rhode Island and Providence Plantations. *This paper was adapted from his speech to the Rhode Island Chapter of the American Academy of Family Physicians in April 1986.*

health plans. Too many citizens do not take a full enough responsibility for their own wellness, ie, witness the amount of cigarette smoking, the lack of exercise, and poor dietary and lifestyle habits.

Joseph Califano, the distinguished former Secretary of Health, Education, and Welfare, in his most recent book *America's Health Care Revolution: Who Lives? Who Dies? Who Pays?* notes that America is awakening to the health care crisis it faces and none too soon. How we will fare during this crisis will be determined by the collective efforts of all of us, government, corporations, physicians, and laymen. As President Lyndon Baines Johnson stated, "Our destiny in the midst of change will rest on the unchanged character of our people and their faith."

There are those who argue that we are headed toward government mandated death control systems, as Americans live longer and the elderly become a larger proportion of our population. This senior boom must be anticipated and planned for before the health care dependent population becomes viewed as a burden to be avoided instead of valued members to be embraced. Califano, in his book mentioned earlier, asserts that we can correct our health care delivery system from its present collision course to one that preserves and enhances our miraculous medical system. He states, "We can shape this incipient revolution into a fundamental transformation of the personal motivations, financial incentives, and institutional roles and relationships of doctors, hospitals, patients, and purchasers of health care. To do so, we must stop blaming others, the doctor, hospital administrator, health insurer, medical equipment manufacturer, drug company, malpractice lawyer, union, corporate lawyer, or government bureaucrat. All of us must look to ourselves to do what we can do differently. We much change the way we think about health care."

One aspect of this health care problem that cannot be ignored is the burgeoning overall liability insurance crisis. This has made itself known specifically to family doctors in the form of huge increases in malpractice insurance rates. The 1960s saw a dramatic increase in the pace of legal change. In the past 25 years, there has been a fundamental alteration in many of the legal doctrines and in the basic balance of the civil litigation system. The tendency has been to extend greatly the definition of liability, resulting in an expensive and unpredictable liability system. Most impacted by today's system are those who provide products and services, such as doctors, manufacturers, and municipalities, who are now at much greater risk of being sued.

Rates for malpractice insurance have risen dramatically over the last few years. For example, in Rhode Island, there was a 49.3 per cent increase in 1985 and a 33 per cent increase in 1984. Last week, the insurance group that provides malpractice liability coverage for the state's health care industry filed a request which would in one year more than double the premiums for nearly 1,800 physicians and surgeons and 550 other health care specialists. That request would raise the annual premium for "high risk" specialists, including obstetricians, cardiovascular surgeons, and anesthesiologists, to about $51,600 a year. Besides physicians and surgeons, the rate increase would apply to other practitioners, including athletic trainers, dentists, and podiatrists. A similar rate request for institutional liability is being prepared.

This explosion of liability insurance rates threatens the careers of many professionals. Obstetricians in New York, California, Florida, and elsewhere are refusing to deliver babies following loss of liability insurance. Oral surgeons in Detroit pay $28,000 a year for liability coverage that cost $10,000 in 1984. A typical neurosurgeon on Long Island saw premiums jump this year from $66,000 to $101,000. Further, rising insurance premiums are tempting older doctors to retire, while they discourage younger doctors from entering high risk areas of medicine.

In the interests of good health care for society as a whole something must be done to combat this problem. Because it is a problem seriously affecting doctors, patients, and health care in Rhode Island, I have cosponsored S 1804, introduced by Senator Orrin Hatch last October, which provides federal incentives for states to adopt professional liability reform. Under the bill, which was developed by the American Medical Association, a state would be eligible for federal grants if the following reforms are adopted by the state and made applicable to cases involving health care malpractice:

(1) Mandatory periodic payments instead of lump sum settlements for awards exceeding $100,000.
(2) Amendment of the collateral source rule to avoid duplicate payments.
(3) A cap of $250,000 on awards for non-economic damages.
(4) Limitations on attorneys' fees to 40 per cent of the first $50,000 of the award, 33.33 per

cent of the next $50,000, 25 per cent of the next $100,000, and 10 per cent of any awards greater than $200,000.

(5) Tightened medical discipline and hospital risk management programs.

These measures would be an important step towards controlling a situation that is increasing health care costs, threatening professional careers, and affecting businesses in many areas.

Another constructive way to reduce health care costs, a method which is most frequently overlooked, is simply by educating the public in a comprehensive fashion about improved health habits. Since 1970, our nation has experienced a decline in deaths from coronary heart disease. The major reasons for this amazing turnaround are startling. Improved eating habits by reducing cholesterol intake accounted for one-third of the drop. The decline in cigarette smoking was responsible for another quarter. Deaths from stroke are also sharply down for much the same reasons. Virtually all factors that substantially increase likelihood of heart disease are within the patient's, not the doctor's, control: smoking, a high cholesterol diet, other improper eating habits, obesity, lack of exercise, and stress. Smoking is slow-motion suicide, a menace that has taken more American lives than all of our wars and all of our automobile accidents combined, not only through heart disease and cancer, but through another two of the ten leading causes of premature death, influenza/pneumonia and accidents.

The impetus for change that will prevent these self-destructive habits will have to come from many different sources. Doctors can contribute to this attitudinal change by increasing their advocacy for health promotion and disease prevention.

The causes for high health care costs are quite obviously varied and complex. However, a central fact about health care and costs in America is that we can do something about them. We must all work together in order to shape a competitive system of excellence which can be utilized for the benefit of all Americans well into the next century.

"He flourished during the first half of the 20th century."



The American physician isn't extinct. But your freedom to practice *is* endangered. Increasing government intervention is threatening the quality of medicine—and your right to function as an independent professional. The government, responding to cost containment pressures from myriad sources, has taken a more active role in legislating reimbursement methods, payment levels and even access to care.

In your fight for survival, the American Medical Association is your best weapon. The AMA is the most influential force in health care. No other organization can so effectively reach the national policymakers who will help determine your future and the future of medicine.

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The Trustees of the Fiske Fund of the Rhode Island Medical Society are pleased to announce the

FISKE PRIZE FOR 1986

to be awarded for an original contribution on

"Cost Containment vs. Quality Health Care"

The award is named after Caleb Fiske (1753-1834), who was a Rhode Island physician and judge, Army surgeon, and a descendent of Roger Williams. Since the prize was initiated in 1836, 87 awards have been made for original contributions. Previous recipients include Charles V. Chapin, Providence, internationally known for his research on public health; David King, Jr., Newport who received the award in 1836 for his paper on "Purpura Haemorrhagica: Its Causes and Treatment"; and Alton Oschner, New Orleans, who received the 1958 award for his paper entitled "Bronchyogenic Carcinoma: Predisposing Causes."

The award for the 1986 Fiske Prize will be a maximum of $1,500. The Trustees reserve the right to award one or more prizes. The competition is not restricted to physicians.

Guidelines:

1) The original and one copy must be submitted by Sept. 1, 1986 to Secretary, Caleb Fiske Fund of the Rhode Island Medical Society, 106 Francis Street, Providence, Rhode Island 02903.
2) All papers must be double-spaced and should not exceed 10,000 words.
3) The award recipient must transfer copyright privileges to the Trustees of the Caleb Fiske Fund of the Rhode Island Medical Society. The paper will be considered for publication in the *Rhode Island Medical Journal*, subject to review by the Editorial Board.

HAVE YOU HEARD?

A comprehensive review of Trexan® (Naltrexone HCl), the first effective non-addictive therapy for detoxified narcotic (opioid) addictions developed by DuPont Pharmaceuticals, was presented at a recent symposium by scientists and clinicians who agreed that the new medication represents a major advance in the treatment of narcotic addiction. Sponsored by the Department of Psychiatry at the University of Pennsylvania Medical School, the conference focused on the widespread potential for using Trexan to treat highly-motivated patients who have been detoxified and who are simultaneously receiving counseling or psychotherapy as well as strong emotional support from family and friends.

The drug marks a major departure from previous treatments in that it allows patients to overcome narcotic addiction in a narcotic-free environment rather than replacing the addiction with dependency on another drug, such as methadone. The first oral narcotic antagonist approved by the US Food and Drug Administration, Trexan works by blocking the euphoric feelings associated with narcotic use. Administered after complete detoxification, the nonaddictive prescription medication is reported to decrease cravings for narcotics and prevents patients from readdiction in the event that the sudden impulsive use of narcotics should occur.

The success of naltrexone has also helped to bring about a new approach to the treatment of narcotic addiction. Traditionally, one goal of treatment has been to achieve complete abstinence from narcotics. Consequently, when a patient suffered a relapse, which was often the case, both the patient and the treatment were branded as failures. More recently, physicians have placed greater emphasis on preventing a sudden relapse from interfering with the effectiveness of long-term psychotherapy and support groups in weaning highly-motivated patients from narcotics.

In its applications in various patient populations, Trexan has proven to be most effective for detoxified addicts who are highly motivated to break their dependency on narcotics. "Stated in a general way, patients with higher levels of psychosocial functioning upon entrance into naltrexone treatment generally tended to do better in the treatment," noted Doctor Arnold Washton, one of the symposium speakers, who added, "In

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short, the more the patient had to lose by continuing to use his drugs, the better he tended to do in treatment, provided the treatment was properly structured for him." Washton cited the results of an investigation conducted by Regent Hospital in New York City which showed that a majority of 129 addicts with jobs in finance, business, and various medical fields successfully completed six months of naltrexone therapy and were still free from narcotic addiction 12 to 18 months later.

• • •

The American College of Emergency Physicians (ACEP) has called for "right to know" laws that will provide workers, communities, and emergency medical personnel with information about poisonous materials in their working or living environment. The proposed laws include hazardous materials that are stored, transported, or disposed of in or near communities. One in every four employees is exposed to substances considered hazardous by the US Occupational Safety and Health Administration, according to a 1977 National Occupational Hazard Survey. Most of these employees are unaware of the presence of any hazardous substance. Moreover, the majority of health professionals, including emergency response teams, have little training in the detection of diseases from poisonous or toxic exposure.

• • •

Visual loss among diabetic patients with macular edema was reduced by half with argon laser treatment in a multicenter randomized clinical trial sponsored by the National Eye Institute, according to the December 1985 issue of the *Archives of Ophthalmology*. Compared were 754 eyes that received immediate focal photocoagulation with 1,490 eyes that were assigned to the deferred treatment group. At three years, only 12 per cent of those in the immediate treatment group has lost a significant amount of visual acuity while 24 per cent of those in the deferred treatment group has done so. In addition to reducing the risk of visual loss, "focal treatment also increased the chance of visual improvement, decreased the frequency of persistent macular edema, and caused only minor visual field losses," according to the study. "The beneficial effects of treatment demonstrated in this trial suggest that all eyes with clinically significant diabetic macular edema should be considered for focal photocoagulation," the report says.

Clinically significant diabetic macular edema is defined as retinal thickening that involves or threatens the center of the macula, a site on the retina responsible for detailed vision. Diabetic patients are also vulnerable to proliferative reintopathy that can threaten eyesight. The total study group included 3,928 patients. Those with advanced proliferative retinopathy received immediate panretinal photocoagulation.

Those treated for macular edema had microaneurysms and other focal leakage sites on the retina and received 50- to 100-micron argon blue-green or green burns of 0.1 seconds duration or less. Power was adequate to obtain definite whitening around the microaneurysm or leakage site. Repeated burns were sometimes needed, according to the report. Changes in visual acuity were calcultaed by subtracting the visual acuity score measured during a follow-up visit from the baseline visual acuity score.

Commenting editorially, the study group observes, "These results substantially increased the number of diabetic patients who might benefit from referral to an ophthalmologist and make it all the more imperative for primary care physicians to play an active role in assuring that their diabetic patients receive adequate ophthalmological care."

• • •

The Inficon Leybold-Heraeus Company recently introduced the FC-1000 Fluoroscopic Imaging Computer® which significantly reduces the radiation dosage administered to patients during fluroscopic procedures. The computer has a built-in noise reduction feature that allows diagnostic-quality images to be taken at very low radiation levels. This feature reduces visual obstruction from the television image and improves the resolution of the information to be digitally recorded in the computer. X-ray images can then be computer-enhanced and stored and hard-copy films can be obtained for diagnoses and permanent patient files. The computer can also control the x-ray generator, making "pulsed fluoroscopy" possible. In this procedure, instead of exposing the patient to a steady stream of radiation, the radiation is supplied in short pulses and the image viewed is constantly updated.

Moreover, the FC-1000 computer can produce very high-quality images by enabling the radiologist to conduct "pulsed progressive readout" techniques. In this method, a short but intense burst of radiation is given, and the resulting image is read out slowly in a progressive fashion

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Do You Know an Impaired Physician?

Treatment of physicians for alcohol addiction shows a favorable outcome in 83 per cent of cases, and treatment of physicians for drug addiction has a 95 per cent success rate. More than 70 per cent of the physicians entering treatment return to the active practice of medicine.

The Rhode Island Medical Society Committee on Impaired Physicians, chaired by Dr Herbert Rakatansky, meets monthly. It is a standing committee of the Society charged with "helping physicians whose professional judgments and capabilities are impaired by their difficulties with chemical dependency or other illnesses."

The Committee handles inquiries in *complete confidence*. If you know of a physician who needs an advocate and support in obtaining necessary treatment, please call or write Dr Rakatansky c/o The Committee on Impaired Physicians, Rhode Island Medical Society, 106 Francis Street, Providence 02903 (401/331-3207).

to a digital memory which stores the image. Once stored, this image may be viewed by the physician and further enhanced by computer functions. This technique promises to replace existing hard-copy filming equipment in radiology, providing the image information in digital form which is stored on computer tape. The conversion of x-ray images into numbers will eventually allow for future integration with picture archiving and communication systems. The trend is for hospitals and imaging centers to be totally computer-integrated.

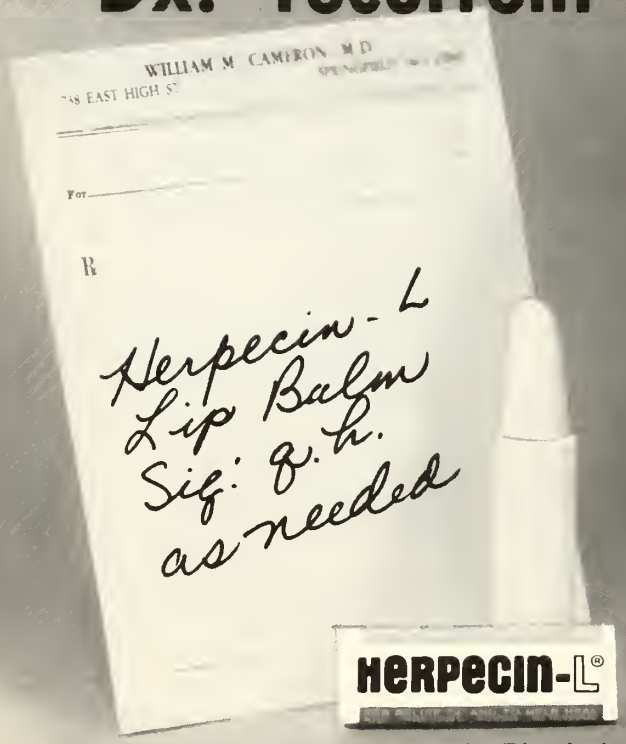
Company officials claim that the Inficon FC-1000 Fluoroscopic Imaging Computer considerably reduces patient exposure to radiation, improves image quality and diagnoses, can be readily integrated with current fluoroscopic equipment, and results in considerable cost savings since film and equipment use is reduced.

• • •

While there often is no economic incentive for drug companies to manufacture drugs for victims of rare diseases, recent cooperative efforts by government, the pharmaceutical industry, and voluntary agencies have made it increasingly likely that these patients will be able to obtain the medicines they need, according to Doctor Edward Remmer, writing in the November/December 1985 issue of *ACSH News & Views*, a publication of the American Council of Science and Health. The Council is an independent, nonprofit consumer education organization promoting scientifically balanced evaluations of food, chemicals, the environment, and health.

The cost of new drug development has increased greatly in recent decades, in part because new regulations designed to ensure that drugs are as safe and effective as possible have also increased the need for costly laboratory and clinical testing before marketing, Remmer noted. "As a consequence," he continued, "drugs with low anticipated returns on investment often do not undergo development quickly. One of the costs of our increased concern over safety and efficacy has been an expansion of the list of 'orphan' drugs. The 1983 Orphan Drug Act and a 1985 amendment, however, have helped to solve this problem. Efforts by the pharmaceutical companies, which sometimes offer orphan drugs free of charge as a public service to physicians, and by voluntary agencies representing victims of rare diseases, especially the National Association for Rare Disorders (NARD), have also played an important role."

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Before prescribing, see complete prescribing information in SK&F CO. literature or *PDR*. The following is a brief summary.

* **WARNING**

This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Contraindications: Concomitant use with other potassium-sparing agents such as spironolactone or amiloride. Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

Precautions: The bioavailability of the hydrochlorothiazide component of 'Dyazide' is about 50% of the bioavailability of the single entity. Theoretically, a patient transferred from the single entities of triamterene and hydrochlorothiazide may show an increase in blood pressure or fluid retention. Similarly, it is also possible that the lesser hydrochlorothiazide bioavailability could lead to increased serum potassium levels. However, extensive clinical experience with 'Dyazide' suggests that these conditions have not been commonly observed in clinical practice. Angiotensin-converting enzyme (ACE) inhibitors can elevate serum potassium; use with caution with 'Dyazide'. Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids, and during concurrent use with amphotericin B or corticosteroids or corticotropin [ACTH]). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Cumulative effects of the drug may develop in patients with impaired renal function. Thiazides should be used with caution in patients with impaired hepatic function. They can precipitate coma in patients with severe liver disease. Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic and hemolytic anemia have been reported with thiazides. Thiazides may cause manifestation of latent diabetes mellitus. The effects of oral anticoagulants may be decreased when used concurrently with hydrochlorothiazide; dosage adjustments may be necessary. Clinically insignificant reductions in arterial responsiveness to norepinephrine have been reported. Thiazides have also been shown to increase the paralyzing effect of nondepolarizing muscle relaxants such as tubocurarine. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. Triamterene has been found in renal stones in association with the other usual calculus components. Therefore, 'Dyazide' should be used with caution in patients with histories of stone formation. A few occurrences of acute renal failure have been reported in patients on 'Dyazide' when treated with indomethacin. Therefore, caution is advised in administering nonsteroidal anti-inflammatory agents with 'Dyazide'. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia is uncommon with 'Dyazide', but should it develop, corrective measures should be taken such as potassium supplementation or increased dietary intake of potassium-rich foods. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Concurrent use with chlorpropamide may increase the risk of severe hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function. Thiazides may add to or potentiate the action of other antihypertensive drugs. Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions, nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances, postural hypotension (may be aggravated by alcohol, barbiturates, or narcotics). Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and respiratory distress including pneumonitis and pulmonary edema, transient blurred vision, sialadenitis, and vertigo have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components. Rare incidents of acute interstitial nephritis have been reported. Impotence has been reported in a few patients on 'Dyazide', although a causal relationship has not been established.

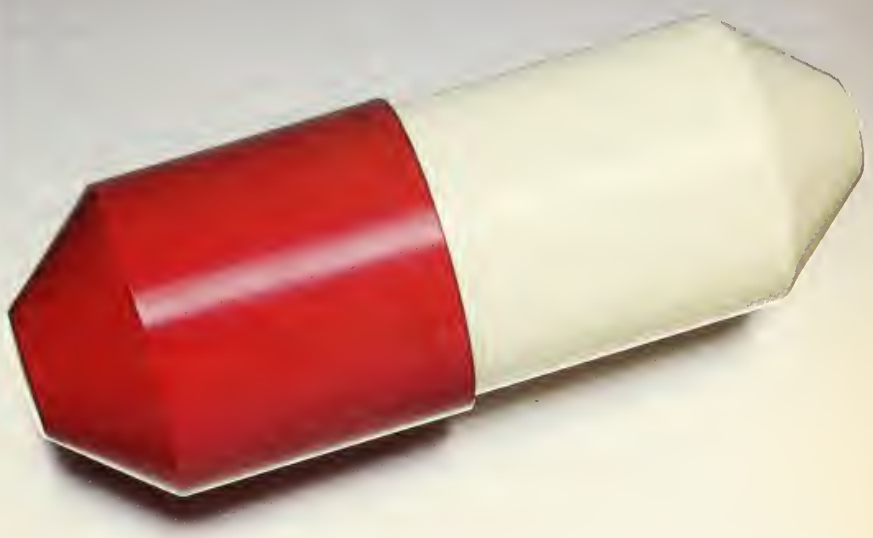
Supplied: 'Dyazide' is supplied as a red and white capsule, in bottles of 1000 capsules; Single Unit Packages (unit-dose) of 100 (intended for institutional use only); in Patient-Pak™ unit-of-use bottles of 100.

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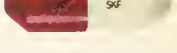
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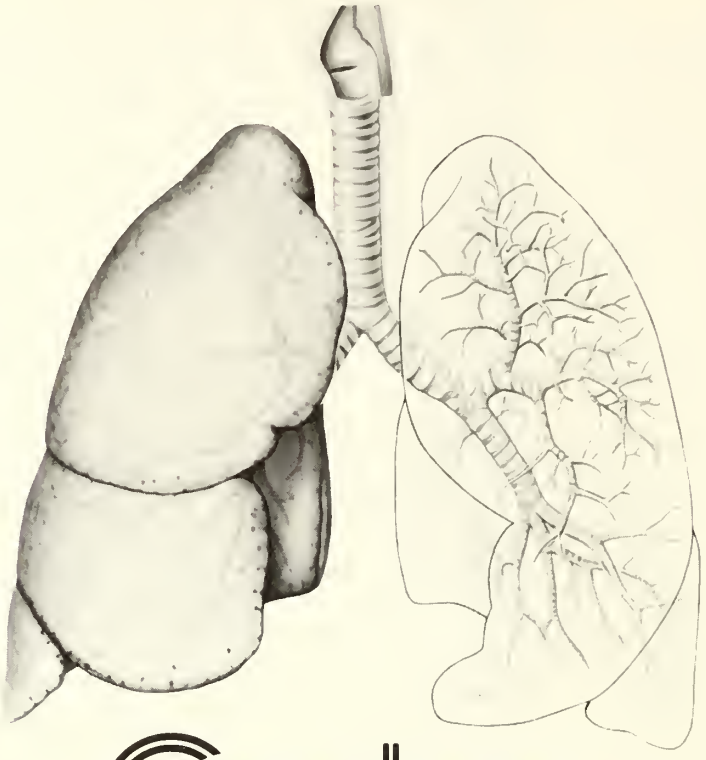
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Summary. Consult the package literature for prescribing information.

Indications: Lower respiratory infections, including pneumonia, caused by susceptible strains of *Streptococcus pneumoniae, Haemophilus influenzae,* and *S. pyogenes* (group A beta-hemolytic streptococci).

Contraindications: Known allergy to cephalosporins.

Warnings: CECLOR SHOULD BE ADMINISTERED CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. PENICILLINS AND CEPHALOSPORINS SHOW PARTIAL CROSS-ALLERGENICITY. POSSIBLE REACTIONS INCLUDE ANAPHYLAXIS.

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Precautions:

- Discontinue Ceclor in the event of allergic reactions to it.
- Prolonged use may result in overgrowth of nonsusceptible organisms.
- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- In renal impairment, safe dosage of Ceclor may be lower than that usually recommended. Ceclor should be administered with caution in such patients.
- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.

Adverse Reactions: (percentage of patients)

Therapy-related adverse reactions are uncommon. Those reported include:

- Gastrointestinal (mostly diarrhea): 2.5%.
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- Hypersensitivity reactions (including morbilliform eruptions, pruritus, urticaria, erythema multiforme, serum-sickness-like reactions): 1.5%; usually subside within a few days after cessation of therapy. These reactions have been reported more frequently in children than in adults and have usually occurred during or following a second course of therapy with Ceclor. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.
- Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.
- Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1%.

Abnormalities in laboratory results of uncertain etiology

- Slight elevations in hepatic enzymes.
- Transient fluctuations in leukocyte count (especially in infants and children)
- Abnormal urinalysis; elevations in BUN or serum creatinine
- Positive direct Coombs' test
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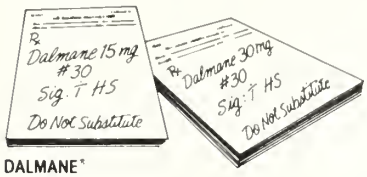
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References: **1.** Kales J, *et al Clin Pharmacol Ther 12* 691-697, Jul-Aug 1971 **2.** Kales A, *et al Clin Pharmacol Ther 18* 356-363, Sep 1975 **3.** Kales A, *et al Clin Pharmacol Ther 19* 576-583, May 1976 **4.** Kales A, *et al Clin Pharmacol Ther 32*:781-788, Dec 1982 **5.** Frost JD Jr, DeLucchi MR, *J Am Geriatr Soc 27* 541-546, Dec 1979 **6.** Dement WC, *et al: Behav Med*, pp 25-31, Oct 1978 **7.** Kales A, Kales JD: *J Clin Psychopharmacol 3* 140-150, Apr 1983 **8.** Tennant FS, *et al* Symposium on the Treatment of Sleep Disorders, Telecanference, Oct 16, 1984 **9.** Greenblatt DJ, Allen MD, Shader RI: *Clin Pharmacol Ther 21* 355-361, Mar 1977



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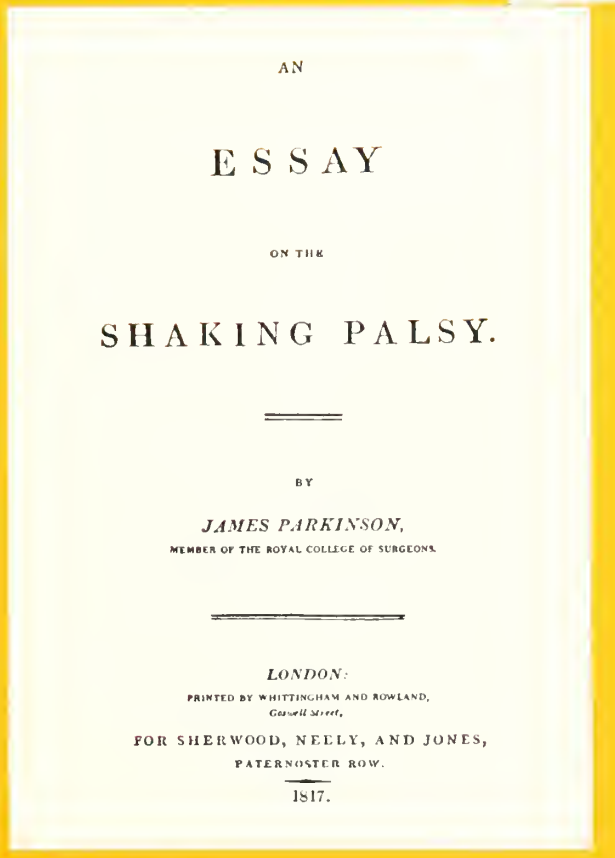
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Rhode Island Medical Journal

July 1986
Volume 69, Number 7

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AN

ESSAY

ON THE

SHAKING PALSY.

BY

JAMES PARKINSON,

MEMBER OF THE ROYAL COLLEGE OF SURGEONS.

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1817.

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JUL 28 1986

Newsletter

RHODE ISLAND MEDICAL SOCIETY
July 1986

Peter D.T. Clarisse, MD, President
Wendy J. Smith, Editor

SOCIETY WINS STAY ON SURCHARGE

The Rhode Island Medical Society has won a stay of the surcharge sought by the Department of Business Regulation (DBR) on all medical malpractice insurance premiums.

In 1985, the DBR ordered the Joint Underwriting Association to assess all current policyholders 16-2/3 per cent of their renewal premiums and all new policyholders 50 per cent of their initial premiums as a mandatory contribution to the stabilization reserve fund. When the JUA was established in 1975, all policyholders were required to pay a 33 per cent assessment. The reserve fund acts as a buffer between any deficits incurred by the JUA and a direct assessment of the participating insurance companies.

The surcharge would have become effective July 1, 1986. The stay will be in force 60 days, during which time the Society will work for a permanent roll-back of the surcharge.

GENERAL ASSEMBLY FINALLY ACTS ON MALPRACTICE BILLS

The General Assembly late last month agreed to freeze medical malpractice premiums at current levels from July 1, 1986 to June 30, 1987. The measure is part of a two-bill package proposed by the Legislative Commission on Medical Malpractice to alleviate the professional liability crisis.

One of the new laws is aimed at reducing the impact of the "significant number of medical and dental claims . . . filed against relatively few health care providers." The preamble to the bill also claims that the monitoring of physicians and other health care providers "has been impeded by the lack of a free flow of information due to a fear of civil suit or other consequences."

Among its key features:

- Expert witnesses in malpractice cases must be qualified by "knowledge, skill, experience, training, or education as experts in the field of the alleged malpractice."
- Plaintiffs and their attorneys who file frivolous suits may be at risk for legal expenses incurred by the defendant.
- The collateral source rule was amended so that juries may be instructed under certain circumstances to decrease an award by the amount of benefits received by the plaintiff from other sources.
- Effective January 1, 1987, prejudgment interest will accrue from the date a suit is filed or formal notification of a suit is given rather than from the date of the alleged incident. This reform applies to all civil actions and not only to medical malpractice cases.
- Periodic payments for awards greater than $100,000 will be considered.
- Cases with a potential for substantial settlements will be placed on an accelerated court calendar.
- Effective January 1, 1987, the Department of Business Regulation must require physicians to carry at least $100,000/$300,000 worth of coverage.

Dealing specifically with the Joint Underwriting Association, the law calls for the Department of Business Regulation to develop a means of merit-rating policyholders so that physicians with a higher level of settlements would pay higher premiums. The Department last year ordered the JUA to propose a merit-rating system.

The law also established a 17-member commission to study over the next year the

MALPRACTICE (continued)

rate structure used by the JUA and other private insurance carriers. The new study commission includes six state legislators, four public members, two attorneys "experienced in medical-legal matters," the auditor general, and representatives of the Society, the JUA, the Hospital Association of Rhode Island, and the Rhode Island Dental Association. The commission is to report its findings by April 1, 1987.

Medical discipline

The second bill, which was the subject of last-minute, closed-door negotiations, revamps the state's medical licensure and disciplinary systems. The current Board of Medical Review, Board of Medical Examiners, and Board of Osteopathy are replaced with a single 13-member Board of Medical Licensure and Discipline. Functioning under the aegis of the Rhode Island Department of Health, the new board will include four medical doctors, one of whom must be a full-time faculty member; two osteopaths; a plaintiff's attorney; a hospital administrator; and four public members with no ties to the medical community. One of the public members must be at least 60 years old. The state health director will serve as chairman. The board will be financed with annual fees to be determined by the health department.

The composition of the board and the independence of its rulings were among the items negotiated during the closing days of the General Assembly. With the prior approval of the governor, the Director of Health will be empowered to appoint a chief executive officer to administer and supervise the board's investigatory and other activities. The board head will be selected from a list of three candidates unanimously supported by a four-person search committee.

The new law provides immunity for all members of the disciplinary board and its staff from claims stemming from their "investigation of the conduct or competence" of physicians. Immunity is also extended to all persons making complaints to the board in good faith. The new board is no longer required to hold public hearings. Adverse determinations will be publicized at the conclusion of the board's proceedings.

Under the new law, the state health director may suspend medical licenses without a hearing if "an immediate danger to the public exists." A hearing must be scheduled within ten days of the action. The current Board of Medical Review does not have the power to suspend licenses without a hearing.

All hospitals, health maintenance organizations, nursing homes, other licensed health care facilities, and the Division of Drug Control must report any action which restricts, suspends, or revokes a physician's privilege to practice. In turn, the board must forward this information within 30 days to all licensed hospitals and HMOs in the state.

The definition of "unprofessional conduct" has been expanded to include "medical malpractice" and the surrender of membership or privileges in a professional association or medical staff while under disciplinary investigation.

RIMS response

In a letter to the Providence Journal, immediate past president Doctor Herbert Rakatansky emphasized that the new laws provide only a starting point for significant tort reform. He objected specifically to the delay in implementing the section on interest payments until next January, noting that the provision may well unleash a flurry of malpractice suits within the next six months. Doctor Rakatansky also said that the presence of a plaintiff's attorney on the new Board of Medical Licensure and Discipline would impede the "spontaneous flow of information" to the board.

GENERAL ASSEMBLY ADJOURNS

After considering a rash of last-minute legislation, the General Assembly finally adjourned on June 25. More than 100 bills affecting medical practice were introduced during the 1986 session. Among the health-related bills considered by the

state's lawmakers were:

- S 2682, sponsored by Senator Victoria Lederberg, which restores the essential elements of the legal process section of the Rhode Island Confidentiality of Medical Information Act. This section, which exempted confidential medical information from discovery in legal actions, was struck down by Judge Florence Murray of the Rhode Island Supreme Court earlier this year on the grounds that it denied litigants due process and inappropriately restricted the court's right to determine the relevance of evidence.

  The new law, which was amended four times on its journey through the legislature, establishes privileged information between physicians and their patients analogous to the relationships between lawyers and clients or priests and penitents. The measure should be able to withstand challenge on constitutional grounds better than the previous legal process section.

- The General Assembly also passed a measure which establishes a "durable power of attorney" for critical health care decisions involving incompetent patients. The measure permits an individual to designate a proxy or surrogate who can act on his behalf if he becomes incompetent to do so. Ordinarily, a "power of attorney" lapses automatically as soon as the principal becomes unable to revoke it. A durable power of attorney, in contrast, is in force only while the principal is incompetent. The approach was pioneered in California.

- Six bills were introduced this year which would have required physicians to accept assignment of benefits as payment in full for Medicare beneficiaries. Well-organized and militant elderly groups lobbied heavily in favor of these measures in the erroneous belief that the bills would save out-of-pocket expenses for older patients in Rhode Island. One measure, introduced by Representative Francis Sherman, was modeled exactly after a similar Massachusetts law requiring physicians to accept assignment as a condition of licensure. In a victory for the Rhode Island Medical Society, the issue was referred to a legislative study commission.

The Society also testified successfully in opposition to a bill introduced by Representative Anthony DeLuca of Cranston which would have permitted unlimited patient access to medical records. Then RIMS President Doctor Herbert Rakatansky and Providence psychiatrist Doctor Robert J. Westlake testified before the House Judiciary Committee that the bill would hamper the efforts of physicians to provide quality medical care.

NEW OFFICERS INSTALLED

Doctor Peter D.T. Clarisse, a Newport radiologist, was installed as president of the Rhode Island Medical Society at the Society's 175th annual meeting on May 30. Other officers include Doctors Richard G. Bertini, a Pawtucket orthopedic surgeon, as president-elect; Milton W. Hamolsky, a Providence internist, as secretary; Kenneth E. Liffmann, a Providence surgeon, as treasurer; David P. Carter, a Pawtucket family physician, as speaker of the House of Delegates; and Boyd P. King, an East Providence nephrologist, as vice-speaker.

Currently chief of staff at Newport Hospital, Doctor Clarisse served as president of the Newport County Medical Society from 1978 to 1982 and as councilor from 1978 until 1986. He chaired the utilization review committee at Newport Hospital for seven years. Doctor Clarisse was president of the Rhode Island Radiological Society in 1980-1981 and Speaker of the RIMS House of Delegates from 1982 until this year. He plans to continue service as chairman of the Public Laws Committee, a post he has held since 1982.

The election of new officers took place at the annual meeting of the House of Delegates. In other actions, the House also:

- approved bylaws changes creating a new category of active direct membership and establishing the Peer Review Commit-

ANNUAL MEETING (continued)

tee on Physician Competency, the Quality Assessment Committee, and the Liaison Committee as standing committees of the Society. Also approved were a recommendation that constituent society presidents be included as voting members of the Council and a revised charge to the Public Laws Committee. The general membership later approved the recommended changes.

- approved the Uniform Rights of the Terminally Ill Act. Developed by the National Conference of Commissioners on Uniform State Laws, the bill would establish a living will mechanism for Rhode Island. Although the General Assembly approved the "durable power of attorney" concept, attempts to enact living will legislation this year were unsuccessful.

- approved with modifications the Interprofessional Code between physicians and attorneys. Proposed by a joint RIMS/Rhode Island Bar Association committee, the code represents two years of work and covers such matters as medical records, depositions, and court testimony. As originally drafted, the code would have required physicians to forward a photostat of medical records without requiring payment in advance. The House requested deletion of the provision concerning advance payment.

Other highlights of the day-long meeting included:

- a luncheon presentation by Doctor John Coury, president-elect of the American Medical Association. Cataloguing what he called the "disappointment of a proud profession," Doctor Coury cited medical liability as the "worst thing that has happened to medicine." Moreover, physicians feel beleaguered as they struggle to defend their tarnished reputation, and financial pressures are pushing medical decisions out of doctors' hands and into the domain of accountants.

- the 1986 Charles V. Chapin Oration by William J. Curran, Frances Glessner Lee Professor of Legal Medicine at the Harvard University School of Public Health and a frequent contributor to the New England Journal of Medicine. Noting that the law has been virtually turned upside down with regard to medicine in the past 30 years, Professor Curran said that public and charitable hospitals, previously immune from suit, now provide large targets, and physicians are especially vulnerable to anti-trust actions.

- an after-dinner speech by Senator John Chafee in which he argued against federal intervention in the malpractice crisis and predicted that Congress, in an effort to cut costs, will radically change the way Medicare reimburses physicians. The changes, Chafee suggested, may come as early as next year.

AMA DEVELOPS NEW MEMBERSHIP BENEFIT

The American Medical Association recently announced the availability of the AMA Members Only Professional Services Account. Provided by the Maryland Bank, NA of Wilmington, Delaware, the Professional Services Account is a credit card processing system which will allow AMA members to accept Visa and MasterCard payments from their patients and to have the added benefit of a very low processing fee.

Physicians who participate in the program will pay a $50 annual fee plus a 1.98 per cent discount rate, ie, the processing fee for charges transacted through the system. All materials, including imprinters, checks, deposit tickets, and office display pieces, will be provided at no cost.

A mailing concerning this service was sent to all AMA members earlier this spring. Additional information is available from Lorna Wunderman (312/645-4785) or Mara Treshansky (312/645-4969) of the AMA Department of Membership Benefits and Research.

Rhode Island Medical Journal

July 1986
Volume 69, Number 7

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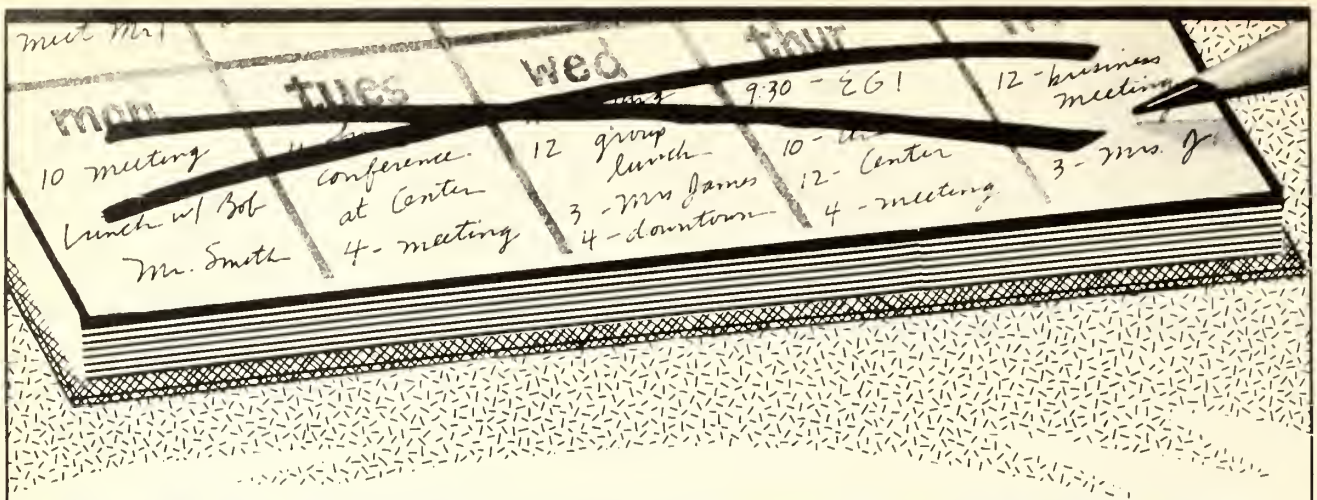
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Title page of Parkinson's 1817 treatise on paralysis agitans. See page 303.



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EDITORIALS

James Parkinson's Shaking Palsy

> So slight and nearly imperceptible are the first inroads of this malady, and so extremely slow is its progress, that it rarely happens that the patient can form any recollection of the precise period of its commencement. The first symptoms perceived as a slight sense of weakness with a proneness to trembling in some particular part; sometimes in the head but most commonly in one of the hands and arms. . . . As time and the disease proceed, difficulties increase: writing can now be hardly at all accomplished; and reading, from tremulous motion, is accomplished with some difficulty. Whilst at meals the fork not being duly directed, frequently fails to raise the morsel from the plate: which, when seized, is with much difficulty conveyed to the mouth. . . . His words are now scarcely intelligible; and he is not only no longer able to feed himself, but when the food is conveyed to the mouth so much are the actions of the muscles of the tongue, pharynx, etc. impeded by impaired action and perpetual agitation, that the food is with difficulty retained in the mouth until masticated; and then as difficultly swallowed.
>
> As the debility increases and influence of the will over the muscles fades away, the tremulous agitation becomes more vehement . . . the chin is now almost immoveably bent down upon the sternum. The slops with which he is attempted to be fed, with the saliva, are continually trickling from the mouth. The power of articulation is lost. The urine and faeces are passed involuntarily; and at the last, constant sleepiness, with slight delerium, and other marks of extreme exhaustion, announce the wished for relief.[1]

Thus did James Parkinson describe the clinical features of a distinguishable, progressive, nervous system disorder which had affected six middle-aged males under his observation. His treatise of some 65 pages, *An Essay on the Shaking Palsy*, was privately published in London in 1817. Parkinson felt that the two pathognomonic signs which separated this illness from other movement disorders were first, "involuntarily tremulous motion, with lessened voluntary muscular power, (tremor coactus);" and second, the "propensity to bend the trunk forwards and to pass from a walking to a running pace (scelotyrbe festinans)." Despite the excellence of this inaugural description, Parkinson's text had failed to note additional features of the disease which are commonly observed today: muscle rigidity, dementia, seborrhea, cataplexy, micrographia, and an expressionless countenance (so-called Parkinsonian facies).

Parkinson's treatise on shaking palsy was published in the sixty-second year of his life, a life filled with notable scientific, literary, and political accomplishments. His published texts included a three volume series on geology and paleontology, *Organic Remains of a Former World*, as well as numerous medical pamphlets selectively written for the laity.

A contemporary of his describes him as follows: "Mr. Parkinson was rather below the middle stature, with an energetic, intelligent and pleasing expression of countenance and of mild and courteous manners; readily imparting information either on his favorite science or on professional subjects; for he was at that time actively engaged in medical practice in Hoxton Square and was the author of several valuable medical treatises."

Parkinson's life was a paradox of parochialism and worldliness. On the one hand he established his immortality as a physician, chemist, geologist, paleontologist, and political reformer; and on the other hand he lived 63 full years hardly ever leaving the immediate vicinity of his father's Hoxton Square home where he was born and where he subsequently practiced. Indeed, records indicate that he left London, and only briefly, on but two occasions.

Some eighty years later, the eminent British neurologist, W. R. Gowers, summarized his experiences with Parkinson's Shaking Palsy (or Paralysis Agitans).[2] Gowers's description (see below) included those rhythmic tremors of the thumb and forefinger which we now call "pill-rolling:"

> The aspect of the patient is very characteristic. The head is bent forward, and the expression of the face is anxious and fixed, unchanged by any play of emotion. The arms are slightly flexed at all joints from muscular rigidity, and (the hands especially) are in constant rhythmical movement, which continues when the limbs are at rest so far as the will is concerned. The tremor is usually more marked on one side than on the other. Voluntary movements are performed slowly and with

little power. The patient often walks with short quick steps, leaning forward as if about to run.

The tremor is an alternating contraction in opposing muscles, causing a rhythmical movement of the parts to which they are attached. It is usually greatest in the hands and fingers, partly from the contraction of the forearm muscles, partly from that in the thenar muscles and interossei; the latter cause a movement of the fingers at the metacarpo-phalangeal joints similar to that by which Orientals beat their small drums. This movement may be chiefly in the thumb and forefinger, as in the act of rolling a small object between their tips.

The great characteristic of the tremor of paralysis agitans is, as Parkinson pointed out, that it continues during rest. The hands go on moving when they are resting on the patient's knee, and the legs when he is sitting. A voluntary movement may stop the tremor for a few seconds, sometimes for many, but it recommences and accompanies the movement. Hence the patient's handwriting reveals his disease; the letters may be fairly formed, but every line is a zigzag.

Speech has usually well-marked characteristics: the voice is monotonous, being no more varied by emotional expression than is the face. There is a delay in commencing a sentence, but, once commenced, the words are uttered rapidly, often with some confluence of syllables; there is "festination" in speech analogous to that in walking — a condition opposite to the separation of syllables met with in disseminated sclerosis. It is as if the patient tried to speak with a minimum of exertion, and to get his utterance over as soon as possible.

The intellect may be unaffected throughout, except by the irritability which usually accompanies the physical restlessness, or by mental depression, which is chiefly the natural result of the physical ailment. Pronounced mental symptoms are occasionally present, however, in the later stages of disease, especially mental weakness and loss of memory, and they may occur early in its course.

The present issue of the *Rhode Island Medical Journal* offers four current observations concerning this disease, described by James Parkinson, which affects an estimated 1,800 Rhode Islanders.

Stanley M. Aronson, MD

References

[1] Parkinson J. An Essay on the Shaking Palsy. Whittingham and Rowland, London, 1817.

[2] Gowers WA: Manual of Diseases of the Nervous System. P. Blakston's Son and Co. Philadelphia, 1903.

Monitoring Drug Safety: A Unique Opportunity for Rhode Island Physicians

In coming months Rhode Island physicians will have the opportunity to participate in a statewide project designed to increase professional vigilance toward drug product safety. Rhode Island, along with Maryland, was recently selected by the federal Food and Drug Administration (FDA) to establish a pilot project to find ways to increase physician reporting of suspected adverse drug reactions. The Rhode Island Adverse Reaction (ADR) Reporting Project is based in the Department of Health and focuses on physicians' unique competence to observe suspected adverse drug reactions and to produce the information necessary to validate and evaluate these suspicions. The discovery in recent years of major drug safety problems, exemplified by Zomax® (zomepirac) and Oraflex® (benoxaprofen), has directed attention toward postmarketing monitoring of adverse drug reactions and underreporting within the voluntary adverse drug reaction reporting system of FDA.

The ADR project, with support from the Rhode Island Medical Society and other key professional associations, offers services designed to equip and encourage physician participation in the FDA voluntary reporting system. The significance of this project lies with the combined recognition of the inherent limits of available safety information when new drugs are introduced in the market, and the increased amount and diversity of drugs consumed by the American population. While diagnostic and therapeutic drug use no doubt reduces significant suffering, increasing public health concern exists over the risks associated with the pattern of increased drug supply and consumption. This pattern shows no sign of abating and can only be expected to accelerate as anticipated population trends unfold. Likewise, public health concerns can be expected to intensify.

More than 1,100 Rhode Island physicians have already contributed to the ADR project by re-

sponding to a recent mail survey on the recognition and reporting of suspected adverse drug reactions. This represents a 75 per cent response rate. Survey results will assist the ADR project in designing appropriate means to encourage increased physician participation and to overcome existing barriers to reporting. Preliminary results indicate that a majority of respondents (54.7 per cent) are familiar with the FDA's voluntary reporting system. However, an even greater majority (56.6 per cent) are not familiar with the specific FDA report forms and report guidelines. Presently, a reporting kit complete with self-mailing, postage paid report forms and report guidelines are being distributed to all Rhode Island physicians. The guidelines stress the need to report selected suspected adverse drug reactions: (1) unexpected reactions, (2) reactions to newly marketed drugs, and (3) all fatal and serious reactions. The guidelines clearly emphasize that submission of a report indicates suspicion of drug-induced illness or injury, not proof or admission of causation. Report forms are addressed to the Department of Health, where they are forwarded to the FDA for review and evaluation.

During the past decade an average of fifty reports of adverse drug reactions annually was received by the FDA from Rhode Island sources. This level of reporting reflects the characteristic underreporting suspected by the FDA throughout the United States. Preliminary results from the ADR project survey make evident that the level of participation by Rhode Island physicians can improve. A majority of physicians (55.8 per cent) report having seen at least one adverse drug reaction among their patients within the month preceding the survey. Close to three-fourths (73.4 per cent) indicate having seen at least one reaction during the past year. Many of these events may have warranted reporting based on the guidelines currently being distributed.

The outstanding response of Rhode Island physicians to the baseline survey is commendable. It serves as an encouraging indication that Rhode Island physicians will not miss this opportunity to demonstrate their professional concern through continued participation in this most important effort. The campaign to promote increased reporting of adverse drug reactions has been launched. In addition to the reporting kit, a series of topical newsletters will be distributed, and a number of medical education sessions are planned throughout Rhode Island to facilitate professional discourse on the recognition and reporting of adverse drug reactions. Watch out for these activities. Further survey results and updates on physician reporting levels will be shared on these pages over the course of the coming months.

H. Denman Scott, MD, MPH
Director
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PRESIDENT'S PAGE

Management by Objectives, Not by Default



Peter D. T. Clarisse, MD

One of the committees that will receive increasing attention during the next year is the Long-Range Planning Committee. This committee was appointed in March to develop a series of goals and objectives for consideration by the Council and the House of Delegates. Once these objectives are clearly established, specific programs can be developed to achieve them.

The activities of this newly-formed committee are crucial for several reasons. First, the Society has extremely limited resources, and it is imperative that our dues dollars be spent in the most effective manner possible. Like all states, Rhode Island faces many problems which affect the future of medical practice, including the burgeoning malpractice crisis, physician disciplinary procedures, the impact of DRGs on the quality of care, and restrictive third-party payment policies. Unlike New York or California, we have a limited dues base of only 1,200 physicians to finance the Society's activities. Yet we still must be as effective in most of the same areas as the larger states. To do this, we must set priorities and target a few matters of concern to all physicians.

Second, the continuity of the Society's activities, especially in the political arena, is essential. Political clout and effectiveness are the name of the game in today's climate. All Society presidents arrive with a set of goals that they wish to accomplish during their terms of office. Concerned about the malpractice crisis, as an example, Doctor Paul Healey served as an effective spokesman and was instrumental in laying the groundwork for many of the accomplishments of the Legislative Commission on Medical Malpractice. His successor, Doctor Herbert Rakatansky, believing that the Society should do more in monitoring the quality of medical practice, established the Peer Review Committee on Physician Competency to help identify and rehabilitate physicians whose practices do not meet acceptable standards. While both are laudable activities, they were conceived and implemented by those physicians in the absence of a long-range plan. Each one had to devise his own strategy. It would have been much easier if plans for implementation were already available.

Third, because most of the problems confronting medicine are not amenable to quick solutions, the Society's goals and objectives should cover at least a three to five year time period. The malpractice crisis provides a perfect example of a

problem requiring a sustained approach. Although the Legislative Commission on Medical Malpractice started its deliberations in mid-1985, it was not until this spring that a package of legislative reforms emerged. Because of the Bevilacqua impeachment proceedings, there were unexpected delays in the House Judiciary Committee. The General Assembly did not act on the bills until the closing week of its session. These reforms, however, provide only a starting point for significant tort reform. The Commission notably failed to act on two key provisions, caps on non-economic losses and limitations on attorneys' contingency fees. It is expected that the Society's future activities directed to the malpractice crisis will focus on these two issues. Even if these reforms were enacted and not challenged in the courts, as the American Trial Lawyers Association attempted to do in California for ten years, malpractice insurance premiums will remain at high levels for a protracted period.

Finally, the responsibility for implementing the Society's programs falls on its officers and staff. It is difficult to function effectively in a situation where objectives and programs are subject to constant change, especially since the major responsibility rests on the president who serves for only one year. Successive presidents have varying interests to emphasize. The establishment of an overall set of objectives will permit us to establish guidelines for evaluating the effectiveness of the Society's programs in meeting these goals. It would institutionalize a process that now goes in fits and starts, depending on the most burning problem of the day.

Among future objectives will be better public relations, more effective management of our limited resources and alternatives, peer review, membership, legislation, and tort reform. By no means is the list meant to be inclusive. To aid in its deliberations, the committee is considering a membership survey to determine what the Society's priorities should be for the next five years.

Planning is often a frustrating and tedious process. Many of us find it much more rewarding actually to do something than to plan for it. Yet unless we plan for the future, the Society will function not by chosen objectives, but by default.

There must be a good reason why we've become the trusted back-up resource for more Rhode Island doctors (and their patients) than anyone else.

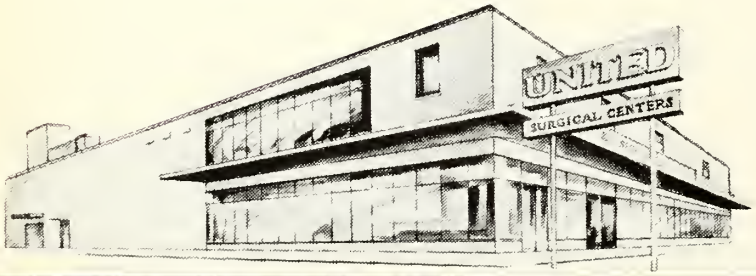
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Parkinson's Disease Resources within Rhode Island

Goal of the Parkinson's Disease Referral and Information Center is to "Ease the Burden and Find the Cure"

Kathryn Cullen, BSN, MS

Parkinson's disease (PD) is a chronic, progressive neurological movement disorder which affects mainly persons over the age of 50. A person with PD lives under the sword of Damocles. He or she is committed to a slow-motion microcosm in a world where time-management is the metronome; where productivity, not patience, is the enduring virtue; and where youth rather than old age is venerated.

The care of the PD patient poses a challenge for physicians, who must identify and coordinate many factors to keep the person functional as well as cognitively intact. A network of professionals and organizations has emerged to help the patient, family, and physician tackle the challenge. The following will chronicle the evolution and contributions of the PD organizations in Rhode Island and will speculate on future projects needed for this purpose.

The following scenarios present typical problems:

> Patient A enters your office with his wife for a physical examination. He is 59 and without significant past medical history. You last saw him three years ago. You notice that he tends to shuffle, has difficulty removing his coat, has a slight tremor in his right hand that abates as he shakes your hand. He no longer appears to be the animated man that you recalled from his last visit. Denying any problems other than slowing down and a few aches and pains, he states that his wife has made him come. She hastens to interject that he appears depressed, does not swing his right arm when he walks, and has had trouble getting out of a chair or rolling over in bed. He looks angrily at her and says that "it is old age — what can you expect?"
>
> Patient B, another 59-year-old with a benign medical history, walks into your office and begins talking even before sitting down. He shakes your hand and says he is glad that you could see him. For the past year he has noticed aches and pains, slowing down, difficulty with his walking, and a feeling of general "restlessness inside." He is always tired, has trouble dressing, and complains of trouble turning over in bed as well as getting in and out of cars. He complains that his handwriting has changed. He thinks that something is wrong, although his wife and another doctor think just that "he is crazy or that it's just arthritis or old age. My wife says that I'm just depressed and always look that way."

After physical examination of both men you suspect PD but will rule out other disorders such as depression, arthritis, or other neurological diseases. You indicate to both men that you suspect PD and that after a few tests you can start medication that will make them feel and function much better. They leave the office after scheduling tests and follow-up appointments.

What is the reaction of each man? Patient A probably leaves the office shocked and in a daze, recalling little of what you explained. Patient B is excited and relieved. At last he feels that he is not a hypochondriac. He too may not recall much of what you said about progression but is happy at last to have a diagnosis that justifies his symptoms.

Later on questions arise for both: How fast and how far will it progress? There is no cure, but do I die from it? How do I tell my boss? What if I can't make it to retirement? Will my children get it? Is it contagious? How did I get it and why me? How will my wife and kids deal with it?

Patients face different functional and psychosocial problems depending on their lifestyles and aspirations, their symptoms, the rate of progression, and their response to medical management.

Kathryn Cullen, BSN, MS, is the Coordinator of the Parkinson's Disease Referral and Information Center, and Clinic Nurse at the Parkinson's Disease Clinic, The Memorial Hospital, Pawtucket, Rhode Island.

Although each man's initial reactions and prognosis are probably different, each has to deal with loss: loss of youth, loss of function, loss of roles, loss of control, and loss of health. Just as with a death, there is a grieving process involving shock, denial, anger, bargaining, depression, and acceptance. Because PD is a chronic and progressive disease, this grieving and coping process will probably follow a dynamic oscillating cycle throughout the following years.

Just as a pebble thrown upon water sends out ripples, so the diagnosis of PD affects the patient, his family, and all his roles and relationships. It was such physical, personal, and social sequelae that motivated Parksonians and their associates to form the Rhode Island Parkinson Support Association (RIPSA).

Frank Toolin, the son of the PD patient, wrote to the *Providence Journal-Bulletin's* "Action Line" in 1978 to determine if there was a PD organization in Rhode Island to help those living with the disorder. Although no such group existed, Don Sakol of the *Providence Journal-Bulletin* asked Harold S. Roberts, a businessman known to have Parkinson's disease, to chair an open meeting for those interested. As a result of their efforts and following a newspaper announcement, 80 persons attended the first meeting of RIPSA in February 1979.

RIPSA has since been established as the Rhode Island chapter of the American Parkinson's Disease Association (APDA). Focusing on creating an atmosphere of acceptance, support, and friendship, the group has attracted speakers on PD who help them learn more about living on a daily basis with the disease. Over the past seven years, meetings have been held almost monthly with 80-150 persons attending, and membership in RIPSA has averaged about 200.

Although neurologists and other health care professionals have been interested in the problem, RIPSA determined that the facilities and clinic services available in Rhode Island did not meet the needs of PD patients. Through the collaborative efforts of RIPSA board members such as Doctors Tamah Sadick, Stanley M. Aronson of Brown University, and Carl V. Granger, Director of the Department of Physical Medicine and Rehabilitation at the Memorial Hospital, a proposal was drafted in October 1980 outlining a plan to establish the Parkinson's Disease Referral and Information Center at the Memorial Hospital. This proposal was submitted in November 1980 to the American Parkinson Disease Association.

Since 1961, APDA has sought to "ease the burden and find the cure" through its sponsorship of research, APDA chapters, and information and referral centers throughout the United States. These centers were intended to provide access to current information on PD and resources available for patients. Although restricted from rendering treatment, the centers identify the needs of the PD population and coordinate programs which help such patients and their families.

In November 1981, the APDA awarded a $20,000 grant for the creation of the Parkinson's Disease Referral and Information Center (PDRI) at the Memorial Hospital. It become operational on May 17, 1982 under the direction of Doctor Granger with Donna LaFantasie as coordinator. Goals of the center were approved in 1982 by the PDRI Advisory Board, comprised of neurologists, RIPSA members, and members of the departments of social service and physical medicine and rehabilitation at the Memorial Hospital. Since then, the PDRI has collaborated with the APDA, RIPSA, Brown University, the Memorial Hospital, local neurologists, and other health care workers to implement its goals. As the PDRI approaches its fourth year of operation, it is worthwhile to review its progress and accomplishments.

The first annual Parkinson's disease symposium sponsored by RIPSA and the newly-opened PDRI was held on June 9, 1982 at Brown University. Local and national experts on Parkinson's disease and rehabilitation contributed to the program, "Parkinsonism: A Perspective for the '80s." This conference provided an encouraging beginning. These yearly conclaves have continued to be one of the most popular events coordinated by the PDRI and RIPSA. Responding to the desire of Parkinsonians for knowledge about the disease, its treatment, and hopes for the future, the symposium planning committee decided to focus on the informational needs of PD patients and their families. The 1986 symposium was held in early June.

Each spring and fall the PDRI morning lecture series and the evening RIPSA meetings offer presentations by neurologists, gerontologists, family practitioners, psychologists, dietitians, social workers, physical, occupational, and speech therapists, nurses, and patients themselves. Topics include maintenance exercise programs, home safety, the use of assistive devices, nutrition, speech and swallowing techniques, as well as other topics.

Support groups in six locations throughout the state present ideas on problem-solving, stress management, and the development of coping strategies. Efforts are made to present accurate information, correct misconceptions, and encourage communication with private physicians, and further compliance with medication regimens. Patients are admonished not to compare dosages of medications or the rate of progression of their disease among themselves, since the course of PD and its treatment is so individualized. Informal instruction and counselling are also available at the Center. The Center also distributes four handbooks published by the APDA, which are free of charge. These include *The Parkinson's Disease Handbook, Speech Problems and Swallowing Problems in Parkinson's Disease, Home Exercises for Patients with Parkinson's Disease,* and *Aids, Equipment, and Suggestions to Help the Patient with Parkinson's Disease in the Activities of Daily Living.* The PDRI is open daily for calls and referrals to community agencies which offer assistance to patients and their families.

The PDRI and the network of individuals interested in PD have provided educational programs for physicians, nurses, therapists, patients, and family members. Efforts are made to reach out to nurses through in-service education. Since its inception in 1982, the PDRI has identified approximately 400-500 of the estimated 1,700 PD patients who live in Rhode Island. According to national Parkinson's disease groups, PD is more prevalent than multiple sclerosis, muscular dystrophy, and amyolateral sclerosis combined and affects one per cent of the population over the age of 50. Currently the PDRI has a very active contingent of "young Parkinsonians" diagnosed in their 30s and 40s. There are, however, many others with PD who are in nursing homes, "in the closet," or who do not know how to ask for or obtain help.

Donna LaFantasie, former coordinator, conducted a self-study of 102 patients and a nursing home survey. Doctor Richard Brown, a rehabilitation psychologist at the Memorial Hospital, also conducted a family coping skills program funded by a grant from the Rhode Island Rehabilitation Network. Moreover, the Center is assisting Doctor Joseph H. Friedman with pending drug studies and a study on the effects of the maintenance exercise program on participants' functioning and psychological outlook. The PDRI also communicates and works with Parkinson's disease centers in Boston and New Haven to share information on forthcoming research projects and programs.

The PDRI is planning in the next year to accumulate more data on PD patients in Rhode Island and to invite medical and graduate students in the areas of pharmacy, nursing, physical medicine, the social sciences, and nutrition to undertake relevant research projects.

Doctor Granger established a multidisciplinary Parkinson's disease clinic at the Memorial Hospital with the help of Doctor John J. Cunningham from the Department of Family Medicine as well as from Doctors Barry Levin and Joseph H. Friedman. Doctor Pasquale F. Finelli, who was recently appointed Director of the PDRI, serves as the clinic's neurologist. Doctor Friedman established a satellite Parkinson's disease clinic at Roger Williams General Hospital in 1984.

Basic to the concept of comprehensive management of Parkinson's disease is a respect and regard for the patient-client and family members as clinic team members. Efforts are being made to facilitate good doctor-patient relationships as well as team member-patient relationships. We especially encourage patients to keep a diary that can help them in giving reliable information about such items as past medical history, symptoms, medications taken, and patterns in side effects such as the on/off phenomenon, wearing off, freezing, dyskinesias, sleep disorders, confusion, hallucinations, and falling. In making the patient and family members partners in setting goals and management, it is hoped that they can abandon the stereotypical "sick role" and assume more responsibility in learning to live and cope with the disease. PD patients who have performed maintenance exercises, participate in therapy, attend lectures, and participate in support groups have benefited functionally and psychologically.

Significant progress has been made toward achieving the goals formulated in 1982 through the help of the APDA, the Memorial Hospital, dedicated health professionals, and volunteer patients and family members. It is hoped that the PDRI can help private physicians and researchers to realize the APDA's mission, "to ease the burden and find the cure."

Pawtucket Memorial Hospital
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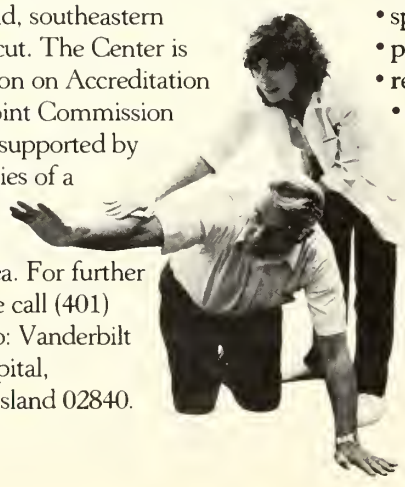


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Subjectively Speaking: A Patient's View of Parkinson's Disease

Tremor and Loss of Spontaneity Have Been the Hardest Things to Accept

Robert Bernen

"Well, Bob, I don't find anything wrong with you."

"What about this congestion in my lungs, doctor?"

"Your lungs are clear."

"Then you can't give me anything for it?"

The doctor shrugged. This was my third visit to him in three months and I was beginning to feel that I was nagging him. Lungs had never been my strong point. Living in the west of Ireland did not help. The first six or seven years there I resisted the mist and damp. Then they began to make their effects felt. Late in the fall I sensed the first slight congestion in the top of my lungs and an uncomfortable hoarseness in my throat. All attempts to clear it away with noisily vibrating exhalations were useless.

When winter came, the congestion got worse and bothered me constantly. At times I succeeded in shifting it a little, and then it felt like a fine line of pain moving through the upper part of my chest. A bit of mucus would propel itself into my throat or the back of my mouth. Most of the time I swallowed it again. Sometimes I was able to spit it out, a little, yellowish lump of phlegm.

So I nagged my doctor and complained about my loss of stamina and lack of energy. I probably did not say anything about feeling weak. It was a point of pride with me to be strong enough to keep up with my farmer neighbors in spite of my city background. Besides, my muscles were all intact. How could I be weak?

When in the late 1970s my illness began to show itself in cryptic, puzzling ways that bore no easily discernible relation to Parkinson's disease, my wife and I were living on the Irish hill farm that had been our home for eight years. We thought the combination of farming and books — reading them or writing them — a good one for two American intellectuals. Our neighbors, born in an age when people were moving away from the hills and the population thinning out — "The hills will soon be waste," one of them told me — found the loneliness and remoteness from town burdensome, especially on long winter nights, but to us they meant quiet and time for reading and writing. When the weather was good we worked. When it rained we read, thought, or wrote, or went to a neighbor's house for long talks by the hearth. In the event, four books came out of our stay there. I think we would be there still if Parkinson's had not intervened.

Most of the visits the doctor got were from the women of the region. He was used to hearing about lack of energy from farm wives who had too much to do and too little help in doing it. Their husbands came to him less often and when they did it was usually with a bad back. Men were reluctant to show weakness. Traditionally, in a farming community that until recently had been largely moneyless, the doctor was not called until the patient was seriously ill or dying. Though farm families had more money than their parents and grandparents had, the custom persisted of calling the doctor only as a last resort.

Newcomers that we were to the life there, we nonetheless felt the force of that tradition ourselves. My yearly visits to the doctor for a "checkup" embarrassed me a little. They were an American custom that we brought with us. They em-

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Robert Bernen, a professional writer educated at Cornell and Harvard Universities, is the author of numerous texts on Irish culture, mythology, art, and travel. Some of his works have been recorded by the Library of Congress.

barrassed the doctor too. He contented himself with methods I remembered from my childhood: stethoscope, thumps on the chest and back, reflexes, a look into eyes, nose and throat, the search for swollen glands. Nothing was ever wrong and I was satisfied with the clean bill of health he gave me. When I started coming to him with my vague complaints, he and I were both sophisticated enough to see a "psychosomatic" origin for them, since he did not find anything physically wrong with me.

Eventually congestion, weakness, and fatigue did get the better of me. I wondered why the doctor had not sent me for an x-ray. Was his stethoscope a sure means of knowing that my congestion was imaginary? I called a friend in Dublin and got the name of an internist from him. Self-referral is not usual in Ireland, but the Dublin doctor gave me an appointment anyway. Listening to my list of symptoms he decided that something was wrong — "seriously wrong," he said — but he would not know what until he had seen an x-ray. "Pleurisy perhaps," he concluded.

I had the x-ray that afternoon. My suspense did not last long. The x-ray technician suggested that I stay around while she developed the negative. I did, and as I stood by, not holding my breath but breathing shallowly and rapidly in spite of myself, she studied the plate. Then she told me with a smile that my lungs were "absolutely clear." There was no trace of anything wrong.

A week later the internist confirmed the technician's judgment. He had asked me to call him, and when I did, he told me briefly that there was nothing wrong with me. I echoed his words feebly and did not protest that if there was nothing wrong with me then what was wrong with me? That would have been too much like inventing an illness and pushing it through at all costs.

Subjectively speaking, these early signs of illness did not appear to me in terms of the three "classic" symptoms that doctors try to find to recognize and diagnose Parkinson's disease. To me my weakness and fatigue brought to mind some of my fellow-students at Cornell in the late '40s and their descriptions of languishing for weeks in the clinic and then at home with what they called "mononucleosis." I thought of worse things as well. A long veterinaries' strike had put an end to the testing of Irish dairy herds for tuberculosis and brucellosis. The strike lasted for two years but we went on drinking milk from our neighbors' cows whenever we went visiting. When testing was resumed some of the local herds were condemned and I wondered if I had picked up brucellosis from the milk. But the doctor and the internist were independently in agreement that nothing was wrong and the matter rested there.

With the hindsight that diagnosis in 1980 brought with it, I looked back over this period of developing illness and gradually recalled other strange things that had been happening to me. Possibly the strangest of all was my total forgetfulness of what I had once known about Parkinson's disease. Even after the tremor started on my right side in 1980 I persisted for months in not knowing what I had. Yet I had known about Parkinson's at least as early as 1952, when a friend of mine explained at length the new science of cybernetics and the invention of computers, the binary system on which they functioned and its relationship to animal motion — the ratchety motion of certain animals such as squirrels and hens, the smooth but nonetheless binary motion of humans. Parkinson's disease came into his explanation as an example of the breakdown of the even balance of opposed muscles, leading to both ratchety movements and tremor. A decade later I read articles about Margaret Bourke-White and her experience: her bold attempt to fight progressive stiffening with exercise, the brain surgery she underwent. And even as late as 1975 or 1976, after seeing my hand follow an unsteady, wavering course to pick up a pen, so that I consciously "zeroed-in" on it, I had said to myself, "Parkinson's disease," followed at once by another thought: "Since there is no cure, why worry about it?" Then I quickly, and successfully, put the matter out of my mind.

There came a period when I stumbled whenever I got up out of my chair, and felt weak in my knees. I started using my arms to push myself up. Seeing me do that a few times, a friend chided: "You're like an old man, Bob." The lesson was quickly learned. With a little conscious discipline I retrained myself to pop out of the chair. Steadying my hand was even easier, and in the years immediately before the tremor appeared my hand seemed steadier than ever.

But other, puzzling things were happening that worried me more, like waking up in the middle of the night with one arm held straight up in the air above me, fingers tightly clenched and with no sensation in them or the rest of the arm. Most of the time the arm was completely paralyzed and I could only thaw it out by rubbing it with my good hand. Sometimes though it responded to my conscious effort to move it without the help of the other hand. I wondered why I never felt pins and needles as the arm thawed, as I should

if I had blocked circulation by lying on it.

Arms were a problem in themselves at bedtime. I found myself wondering what to do with them, how to arrange them so that I would not have to lie on them and so that they would leave me comfortable. Useful by day, at night they seemed like superfluous appendages, always in the way. I asked friends what they did with their arms when they went to bed, but they were only puzzled by my question. It was something they arranged spontaneously, without being conscious of doing it.

Were experiences like that part of Parkinson's, or was it just coincidence that they were happening at the same time? Plenty of peculiar things were going on. Some of them were related to what I called "reflexes." I remember a day when I unintentionally put my hand on the cast iron, solid-fuel stove we used to heat our kitchen. The stove was hot, but I did not feel any heat. And yet, though there was no sensation of being burned, my mind registered the importance of taking my hand away from the hot metal as quickly as I could. Still, my hand refused to move. Finally I did feel my fingers being burnt and was able to lift my hand, too late to avoid a bad burn. The same thing happened a number of times. What was peculiar to me was that there seemed to be so much time during which my fingers in contact with the burning surface did not feel any pain, while my mind registered what was happening and tried, without success, to get my hand to come away.

Was this related to the numbness that sometimes settled on the very top of my head and parts of my face, mainly my jaw, which felt the way it did after a dentist's shot of anesthetic? Or to my middle of the night "marble arms?" Something that bothered me more and gave me more worry was a confusion that occurred in my hearing. Living on a remote dirt road where vehicles seldom came, it was natural for us to learn to identify approaching cars or trucks by their sound. The long uphill approach made them gun and strain more loudly than on level ground and we heard them as much as five minutes before they actually arrived. But at a certain point I found I could no longer distinguish cars from tractors, or either of them from planes flying overhead. I lost the ability to tell which direction they were coming from and would look at my wife for the answer. She became so used to my puzzled look at such times that she supplied the answer before I asked the question. In time the confusion went so far as to include natural sounds, and I was impressed by how nearly a kettle of boiling water could resemble the sound of an approaching tractor.

The tremor that began in the late winter of 1980, at first for only a few minutes every morning as I woke, quickly grew longer lasting and stronger and led to diagnosis in July of the same year. Then my awareness of my difficulties increased rapidly, as though the knowledge brought by diagnosis were a factor in making my symptoms worse. It was with great reluctance that I read the newsletters and descriptive pamphlets published by the various foundations. My tendency was to recognize normally late symptoms in myself and to see myself in terms of the most advanced stages of the disease. My own embarrassment at the tremor and my tendency to withdraw and become recluse were my largest handicaps. Even when I made a conscious decision to accept my condition it took a considerable effort to go on seeing friends as I had before.

During that first difficult period when self-imposed loneliness and constant embarrassment dominated my life, I started keeping a journal. My purpose was not primarily to record the experience of my illness, but simply to exercise my hand and keep it as limber as possible — in short, to practice my handwriting. A steno notebook was easy to take along wherever I went, and in spare moments I opened it and wrote whatever came to mind. I found myself recording my everyday life at that time, but with a good deal about Parkinson's too, either the daily experience of the disease as I felt it then or my recollections of its early manifestations in the preceding ten or twelve years.

Thus it was that I thought back to the day I first became aware that my right arm was not swinging as I walked, that my right foot had turned inward, making me pigeon-toed, and that a long-lasting sense of fatigue began. The date — the end of the first week in May 1978 — was marked precisely in my mind because it followed the unusual exertion of a long hill walk with friends who were more ambitious and more vigorous than I. A few weeks later I started telling them that I had never recovered from that hike. They were incredulous, and I shared their bewilderment, but my inability to keep up with the summer work of the farm was a daily reminder of my poor condition.

Then I began to remember the little signs — external indications of something wrong — and symptoms — internal sensations of something

wrong — that had puzzled me at the time I first noticed them. One sign was what I perceived as a defect in my typewriter, which started printing capital letters halfway above the line. To make this defect more annoying, it printed the lower case letter that followed half below the line. Another was the persistent tendency of my left-hand shirt sleeve to unroll and flop down on my forearm a few minutes after I had rolled up my sleeves for work. As this happened with any shirt I was wearing, I should have recognized the fault as mine, but I blamed the shirt and reasoned that as all my work shirts were of the same brand, so they all had the same fault. It was always something external that I blamed for these signs of failing muscle tone. Aware that I no longer had the strength needed for jobs like fencing or mowing, I was unaware that the efficiency of my muscles was failing even in small movements. Instead, I complained of the inferior quality of modern typewriters and modern products in general and managed to find external objects to blame for my difficulties.

There were other signs and symptoms that I paid less attention to or failed to notice at all. When my wife pointed them out to me, I quickly thought of reasons to see them as a natural part of being middle aged. In some cases I even welcomed them as an improvement on former habits. We had both been rapid walkers and did not find it difficult to walk five miles to call on friends and five miles home again. Now, my wife pointed out, I had slowed down noticeably. I replied that that was only on hills — I had already become aware that hills were harder to climb — and that I was still fast enough on level ground. Besides, a farmer I sometimes bought sheep from, and whom I admired for his skill as a breeder, had told me that where farm work was concerned he and his brothers had felt themselves grow stronger up to the age of forty-five, after which the decline began. I was fifty: that accounted for my slowing down. In any case, I argued, going slower was better than my former way of walking too quickly. The same slowing down had occurred in my speech, and there it was clearly an improvement, for I had always talked too fast. Now I was considering what I said more carefully and measuring my words. With these and similar arguments I rationalized the changes I was undergoing and even saw them as benefits.

At the same time my handwriting was becoming very much smaller and more rapid. Instead of seeing this change in my penmanship as a symptom of illness, I thought of it as a conscious development, not something that was happening to me, but something I had willed. At the time, I was beginning work on a travel book in the form of verbal descriptions of things I saw and heard during a vacation in France. Even when writing at my own desk I had often felt the words and sentences tumbling into my mind with such rapidity that my hand could keep pace with them only with difficulty. As I raced to record one idea, one sentence, the next was already fully in my mind. A double effort was required: writing one sentence, memorizing the other. This often continued for an hour or more, at the end of which time my mind and hand would be exhausted. When my new small swift way of writing developed, I saw it as a natural accommodation and solution to that problem. Using an old-fashioned Parker fountain pen and liquid ink, my hand skimmed over the surface of the paper swiftly and lightly, keeping up with my racing thoughts. A welcome feature of this new way of writing was that I could work for long periods without writer's cramp. On the other hand, the indications of words and letters were sometimes so condensed as to be almost illegible. My longhand script was in fact becoming a kind of shorthand that had to be transcribed the same day. If I put off typing up my notes for twenty-four hours, I was in danger of not being able to decipher them at all. What I find remarkable now is the way these signs of developing Parkinson's — walking slower, talking slower, writing smaller — seemed to me to be desirable changes in my way of doing things, and by no means signs of approaching illness.*

When the tremor made it impossible to ignore the disease any longer, I still did not sense my illness in terms of stiffness and slowness of movement. Instead, I was painfully aware of two things: the first, my uncontrollable shaking, the second, my loss of spontaneity. The first meant that I could not be still when I wanted to rest, the second that I could not move freely and fully when I wanted to be in action. Between them they made life seem a burden that it would take a long effort to grow used to.

Nothing has been able to make up for the loss of spontaneity. After the tremor, it was the hardest thing to accept. The realization that I was losing for good the capacity to carry out a willed movement without extra thought meant that life would be more a performance than an experience. Gradually I got used to that loss and adjusted to the necessity to will every action twice.

It was all part of the larger adjustment to my new slowness, unsteadiness, and uncertainty. I have been at it for so long now that it seems normal, and I have even forgotten that that is what I do. Only from time to time, at moments when my medicines work perfectly and my right arm reaches out and does things of its own accord, do I experience again that sensation, the spontaneous action of a body that knows what I want done before I have thought about it myself. When spontaneity returns temporarily now, it can be as much a liability as a pleasure. I notice myself doing things without the judgment I used to have, moving through a crowd of people, say, without thinking about the intricacies of slipping through narrow places by twisting my shoulders to accommodate. The spontaneity returns, but the fine control is not there. So even in moments of spontaneity I still need conscious control to prevent an action from going too far, too quickly. Slowness becomes desirable.

I always disliked people with tremors or tics and avoided their company. Now I have the tremor and would avoid myself if I could. Instead I go around everywhere with myself just as before, resist the recluse tendency, cultivate a sense of humor to put others at their ease, and try to accept this new condition of life. The tremor and the loss of spontaneity have been the hardest things to accept. They make my life look to me like an awkward coordination of two unlike personalities, one who shakes while the other, embarrassed, looks on helplessly; one who wills, while the other reluctantly obeys; a constant conflict of selves. It may seem strange to talk of being two persons, but that is the way having Parkinson's disease feels to me.

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* The earliest symptom I was ever able to recall in this way was in 1969, with pains that occurred in each shoulder whenever my wife and I went for the long weekend walks that we almost never missed, rain or shine. The usual distance was about twenty-five miles, and, while my feet and legs did not feel tired or sore after the walk, I consistently felt pains in the region of my shoulder blades. My wife and the friends we walked with did not have them, and that made them all the more puzzling. After diagnosis I was puzzled too at the thought that the earliest symptom may have occurred more than ten years before the tremor.

In informal conversation recently with Doctor Roger Duvoisin, Chairman of Neurology at Rutgers, the talk went round to the subject of cigarette smoking and the incidence of Parkinson's disease. A persistent statistic shows that people who have Parkinson's disease are seldom smokers, or have been smokers but have given it up, while cigarette smokers seldom get Parkinson's disease. The question we discussed was whether cigarette smoking is prophylactic for Parkinson's or merely an indication that the individual was not at high risk for the disease, while conversely an aversion to smoking indicated a tendency towards the disease. Doctor Duvoisin supported the second explanation and called the aversion a "behavior marker."

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Recent Research Advances in Parkinson's Disease: Part I

Chance Discovery Has Provided Animal Models for Research

Joseph Friedman, MD

Parkinson's disease (PD) occupies a special niche in neuropharmacological history. It is the first such disease for which a therapy was designed. The neuropathology of the disease had been well described since the early twentieth century, but the neurochemical deficits were not understood until 1963 when Hornykewicz discovered the pronounced loss of dopamine in the basal ganglia of Parkinsonian patients.[1,2]

It was recognized that dopamine itself could not be used to treat PD since it does not cross the brain barrier and produces profound cardiovascular side effects. Some workers thought that the remaining cells in the substantia nigra would absorb L-dopa, a dopamine precursor, thus shifting the synthetic pathway into producing more dopamine. However, initial attempts to increase brain dopamine by supplying L-dopa were not successful. Side effects, especially nausea, occurred in most patients taking large doses of the drug. Moreover, an enzyme located in the liver broke down L-dopa to dopamine (recently rediscovered to be a useful method of supplying oral dopamine in the treatment of congestive heart failure[3,4]), thus lowering the serum level of L-dopa available to the brain and for treating the PD. Perseverance and administration of L-dopa at slowly increasing strengths revealed that most patients eventually demonstrated marked improvement without significant side effects. This was a pronounced triumph for a rational approach to the symptomatic control of Parkinson's disease.

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Unfortunately there have been limits to the usefulness of L-dopa. Despite better tolerance of higher L-dopa levels with fewer side effects by using the combined drugs carbidopa/L-dopa (the former blocks the enzyme which metabolizes L-dopa to dopamine in the blood), it was soon learned that many patients developed new drug side effects within a few years and sometimes stopped responding to the drug at all. Some investigators began to be concerned that the L-dopa was itself causing a worsening of the PD. While the patient was more mobile and less tremulous on the medication, it was feared that the underlying disease process, the death of brain cells, was being hastened.

Since the advent of L-dopa, no major changes in the understanding of PD occurred four years ago when "one of the most remarkable stories of recent medical history" unfolded.[5] In 1976, a chemistry student developed a Parkinsonian syndrome after using a synthetic heroin-like drug.[6] The significance of this finding was unrecognized until 1982 when a mini-epidemic of the identical Parkinsonian syndrome occurred in the San Francisco Bay area among intravenous drug abusers. The source of the problem was tracked down to a single "kitchen chemist" who had been illicitly manufacturing a meperidine-like drug, 1 methyl-4 phenyl-1,2,3,6 tetrahydrophyridine (MPTP).[7] The student affected in 1976 died of a drug overdose in 1978. An autopsy revealed isolated destruction of the zona compacta of the substantia nigra, the main area affected in Parkinson's disease. None of the other changes seen in PD were present.

The identification of a Parkinsonism-producing compound, although synthetic, immediately suggested the possibility that PD itself was the result of an environmental toxin and that sci-

entists now had a clue, albeit a small one, to its nature. Probably more immediate was the prospect of using the drug to develop good non-human models of PD, which had not existed up to that time. In fact, an explosion in PD-related research occurred because of MPTP's usefulness in developing animal models.[8-12] In June 1982, the first MPTP patients were admitted to the hospital. By July 1983, the first primate model of PD, using parental MPTP to produce the syndrome, had been published in a scientific journal. In 1985, the first conference on the subject was held. More than 200 laboratories had been using the drug experimentally by that time.

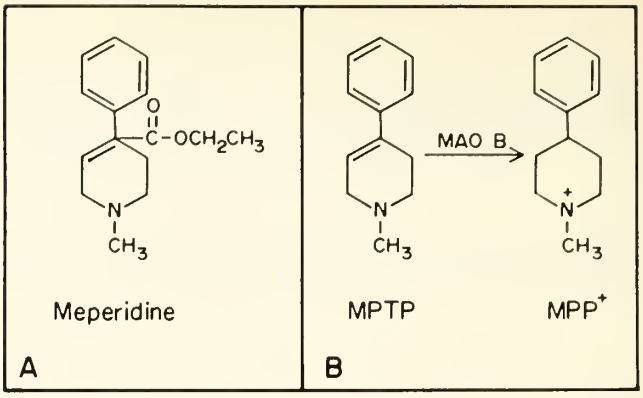


Fig 1: Meperidine and its metabolite, MPP+.

MPTP has created the possibility of a leap forward in understanding, treating, and possibly preventing the disease or interrupting its progression in those already affected. We have already learned that virtually all the clinical signs of PD, tremor, stiffness, akinesia, freezing, bradykinesia, micrographia, and seborrhea, are due to the lesion in the substantia nigra. Thus, the other pathological findings in PD have an unknown, but apparently subclinical impact. Treatment of PD therefore can focus entirely on this region.

To date, published studies have demonstrated the development of MPTP models of PD in rhesus monkeys, squirrel monkeys, marmosets, salamanders, and frogs.[8,11] An as yet unpublished study has demonstrated a Parkinsonian leech, probably the first non-vertebrate model of any human nervous disease.[12] Importantly, the primate models and the leech respond to L-dopa therapy. The primate models will be extremely useful in helping to answer several questions about PD.

Since new drugs will be tested on these animals before human trials are undertaken, the models will help in the development of therapies. Probably more important will be the use of the primate model to study the long-term consequences of L-dopa therapy. Serious problems occur in half the Parkinsonian population after treatment with L-dopa for three years.[13] Such problems include "wearing off," in which the early daily doses of L-dopa are effective, but the later ones are not; "variable response," in which the effects of L-dopa are unpredictable; and most perplexing of all, the "random fluctuation," in which a patient switches "on" and "off" seemingly at random times during the day, unrelated to the drug schedule. In addition, various secondary movement disorders develop after prolonged L-dopa administration, including chorea, dystonia, and myoclonus. None of these relatively common problems is readily amenable to study in human subjects since study of the brain with implanted devices or sacrifice of the subject to study the brain are obviously not feasible.

One question which should be easy to answer using the MPTP primate model of PD has to do with whether or not L-dopa hastens the course of PD. There has long been a theory that free radicals, highly reactive oxidative molecules, are involved in the slow changes that occur in cells as they age and eventually die. The metabolism of dopamine generates free radicals. Therefore, a concern has arisen that L-dopa therapy, which increases dopamine production in the remaining cells of the substantia nigra, may actually be hastening the demise of such cells even as it ameliorates the symptoms and signs of the disease. It will be easy to treat one group of MPTP primates with L-dopa and then compare it with an untreated group to see if the number of cells remaining and their function are altered.

The value of the amphibian models lies in their low cost, easy care, ready availability, and the ethical advantages of not using primates for experiments. It may make sense to test some drugs on amphibians before use of monkeys, although some drugs may be metabolized differently in different phyla. The leech, an animal with a primitive nervous system, will be a useful model for studying individual cell changes. As the leech responds to L-dopa therapy, it may even be possible to study single cell interactions before therapy, during early therapy, and after prolonged L-dopa use.

The fact that a toxin exists which may selectively destroy only one region of the brain has

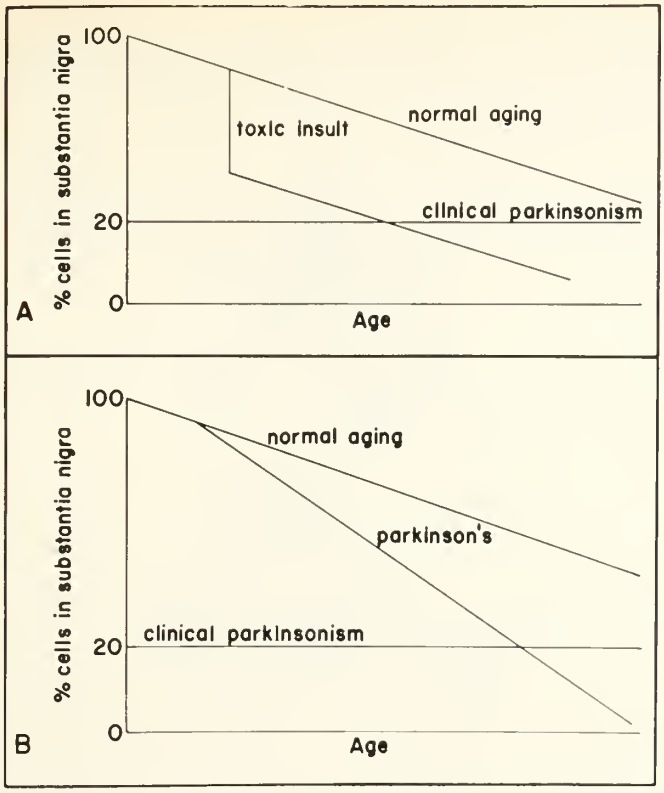


Fig 2: A. Graph showing hypothesis that Parkinson's disease is caused by discrete toxin exposure and normal aging; B. Graph showing hypothesis that Parkinson's disease is the result of continuous low-grade toxin exposure.

suggested the possibility that some environmental toxin may cause PD. There are two theories of causation. One maintains that a single or a small number of exposures cause the death of cells in the substantia nigra and the other areas involved in PD, but that the lesions are subclinical. In human subjects with PD and in primate models as well, clinical evidence of Parkinsonism occurs only after 80 per cent of the cells in the zona compacta are destroyed.[14] It is possible, therefore, that relatively early in life one loses a certain percentage of brain cells, but is unaware of the loss. As the individual ages normally and more brain cells die, he reaches the 80 per cent threshold and then develops clinical Parkinsonism while an individual not exposed to the alleged toxin never reaches this benchmark (see Figure 2). Several San Francisco intravenous drug users have now been identified with a limited exposure to MPTP, but without Parkinsonism. They will be followed to see if they eventually develop the disease.

The second toxin theory suggests that PD may be the result of a chronic low-grade environmental exposure. Circumstantial support for this theory arises from the chemical similarity of MPTP to paraquat and other insecticides, the presence of geographic clustering of PD cases in certain epidemiological studies,[15,16] the lack of clear clinical descriptions of Parkinsonism in any literature predating the Industrial Revolution and its environmental pollution, and a recent study[17] demonstrating hepatic detoxification enzyme deficiencies in a high percentage of PD patients.

The toxicology of MPTP is partially understood. MPTP itself is nontoxic. It is metabolized by the enzyme mono-amine oxidase B (MAO B) in the glial cell to MPP+, which is then taken up by the dopamine uptake mechanism in the zona compacta cells, killing these substantia nigra neurons.[18] By inhibiting MAO B or the dopamine uptake mechanism, MPTP is rendered nontoxic.[8-11] Deprenyl, an extremely safe drug, is an MAO B inhibitor currently available in Europe as a mild agent to treat symptoms of PD. It also prevents MPTP toxicity in primates. Although there is no hard evidence linking MPTP or other toxic agents to PD, a three-year national cooperative study is planned to start in July 1987, if funded, to treat early PD patients with deprenyl to see if the progression of the disease may be halted. Under consideration is the concomitant use of Vitamin E, an anti-oxidant, to test the theory that increased free radical formation causes disease progression. As study patients will not be treated with other anti-PD agents, it will be easy to see if disease progression is retarded. A positive effect of these agents would be the most important clinical neurological breakthrough since Putnam and Merritt developed an animal model of epilepsy in 1938 and demonstrated the efficacy of phenytoin in controlling seizures.

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Mental Disorders in Parkinson's Disease

Psychiatric Problems, Dementia, and Subtle Cognitive Impairments May Be Associated with This Disorder

Robert Rafal, MD

Since the publication of Parkinson's *Essay on Shaking Palsy* in 1817, motor dysfunction has been recognized as the cardinal feature of this disease: akinesia and bradykinesia, resting tremor, rigidity, and loss of postural reflexes. Marsden has recently emphasized that mental life can remain remarkably unaffected, even in patients with severe motor disability: "patients with Parkinson's disease continue to paint, compose, play musical instruments (albeit with less facility than previously), write verse and prose, and appreciate fine wine and food. The senses are not dulled and the memories necessary for the execution of these special skills are preserved."[1] However, even Parkinson in his seminal monograph, while emphasizing "the senses and intellect are uninjured," nevertheless commented that mental disturbances do occur in the form of "depression and terminal delirium."

Succeeding generations of physicians have had different perspectives upon the mental disorders which can accompany Parkinson's disease. For a half century following the 1918-1920 pandemic of encephalitis lethargica, a large proportion of the patients with Parkinsonian symptoms suffered from post-encephalitic Parkinson's disease. These patients, having suffered encephalitis, had widespread involvement of the central nervous system, including basal ganglia and cortex. Therefore, physicians caring for these patients often found that mental disabilities were a dominant element of the clinical course. By the time L-dopa therapy was introduced in the early 1970s, however, post-encephalitic disease had largely vanished. Physicians in this era were impressed by the dramatic response of idiopathic Parkinson's disease to treatment. By replacing deficient dopamine neurotransmitters in these patients, virtually all of their signs and symptoms could be alleviated. Patients under treatment frequently appeared to be entirely normal with no clinical evidence of neurologic or mental impairment of any kind. As a result of this dramatic advance, a perspective emerged in which Parkinson's disease was viewed as representing a pure basal ganglia disorder due to deficient dopaminergic input to the striatum. For a time, medical thinking lacked an adequate appreciation for the heterogeneous nature of Parkinson's disease, both with regard to its pathologic and neurochemical abnormalities and to its clinical symptomatology. Less than five years after the advent of L-dopa therapy, however, we were forced to take a more sober view of Parkinson's disease. As patients with this disease lived longer with control of their motor disabilities, it became increasingly clear that mental signs and symptoms were indeed part of the natural history of this disorder in a sizable proportion of afflicted patients.

Over the past ten years a more systematic approach to understanding this natural history focused renewed interest on the depression which Parkinson noted in his monograph. Since patients were living longer with control of their motor symptoms, the "terminal delirium" that Parkinson noted emerged in the form of chronic dementing illness in a certain proportion of patients. A better appreciation and understanding of these disorders is important, both because they represent a major challenge in therapeutic management, and because they may provide insight into an understanding of what role the basal ganglia may play.

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Psychiatric Disorders in Parkinson's Disease

Parkinson's disease produces a chronic disability and it is perhaps not surprising that depression is common in this disorder. Nevertheless, when systematically compared to other disabling diseases, such as rheumatoid arthritis, it has been shown that the incidence of depression in Parkinson's disease is greater than that which could be anticipated on a situational basis. There is a growing consensus, therefore, that the depression which commonly occurs in Parkinson's disease has a strong endogenous component. The neurochemistry and neuropharmacology of this endogenous depression in Parkinson's disease has been the focus of considerable interest.[2-4]

A number of neurochemical disturbances may play a contributing role. Perhaps the most obvious possibility is that dopamine deficiency accounts for or contributes to depression. The motor disability of Parkinson's disease is due to the deficiency of dopaminergic substance in the basal ganglia. However, other dopamine pathways exist and are thought to be involved in the emotions. Alteration of neurotransmitters other than dopamine also occur in Parkinson's disease.[5] Recently Mayeux and his coworkers have provided evidence that depression in Parkinson's disease correlates better with alterations in serotonin metabolites in the spinal fluid than with other neurotransmitters, including dopamine and neuradrenalin metabolites.[6] Regardless of its neurochemical basis, it is important for clinicians to recognize that depression can be a major problem in Parkinson's disease, and that it may have an endogenous component amenable to treatment with antidepressant medication.

Psychosis, in the form of full-blown thought disorder, delusions, and hallucinations, does occur in a small minority of patients with Parkinson's disease and may even herald the disorder before the appearance of significant motor disability. Most commonly, psychosis in Parkinson's disease takes the form of an agitated psychotic depression rather than a schizophreniform disorder. The emergence of psychotic symptoms in patients with Parkinson's disease is an ominous development. All of the available antipsychotic neuroleptic agents have antidopaminergic modes of action and therefore can aggravate the motor symptoms of Parkinson's disease. A new antipsychotic agent, clozapine, which has low antidopaminergic activity, is not currently available on the market. In some patients, control of psychotic symptoms with neuroleptic agents can be achieved only at the price of worsening motor disability. However, since the psychosis seen in some Parkinson's disease patients takes the form of an agitated depression, lithium may be of considerable benefit and may succeed in controlling psychotic symptoms without recourse to the use of antidopaminergic neuroleptic agents.

A toxic delirium due to antiparkinsonian medication can produce vivid hallucinosis. It is important that these not be confused with a psychotic disorder *per se*. This toxic hallucinosis can result from any of the antiparkinsonian agents, including L-dopa, anticholingergic agents, amantadine, or bromocriptine. This toxic delirium constitutes a striking and characteristic clinical picture. Typically, patients have formed visual hallucinations, usually of living creatures. Animals and people are commonly seen. Although they are often distorted in unreal ways — "I see little people running around under the table" — patients who experience them are quite aware of the fact that they are not real. Patients usually have insight into the hallucinatory nature of their experience and do not have a primary disorder of reality testing. The hallucinations are not accompanied by thought disorder or delusions. Unlike the hallucinations which are characteristic of psychotic processes, auditory hallucinations, especially of a persecutory nature, are not a part of the syndrome. It is important that the nature of the hallucinatory disorder be recognized since its treatment involves reduction of antiparkinsonian medication, not the use of psychotropic medication.

The hallucinatory disorder due to antiparkinsonian medication often occurs as part of a symptom complex associated with drug toxicity.[7] It tends to occur in patients who have been under treatment with antiparkinsonian medication for many years. In general, most of these patients have at least a mild degree of dementia. In addition to the hallucinations, they typically have other manifestations of chronic drug toxicity, including dyskinesias, sleep disorders (including insomnia and sleep myoclonus), and periods of confusion. The advent of this symptom complex is an indication for the reduction of antiparkinsonian medication. In most instances, this can be accomplished without unduly prejudicing control of motor disability. However, this is not always the case, and in individual patients it may be necessary to find a dose and combination of medications which can reduce mental symptoms to a minimum, while maintaining optimal control of motor disability. This may be a difficult goal

to achieve. Often, the patients serve as the best guide to the physician in achieving a compromise. Many patients are quite willing to tolerate occasional mild hallucinations to maintain their mobility. Nevertheless, it is important for the physician to recognize these symptoms for what they are, a sign of chronic drug toxicity, and to reduce the antiparkinsonian regimen to a minimum.

Dementia in Parkinson's Disease

In recent years, as therapy for Parkinson's disease has become more successful, it has become evident that dementia occurs commonly at some stage of this disease, and ultimately will afflict at least a third of the individuals suffering from this disorder. The cause and characteristics of the dementing disorder which accompanies Parkinson's disease remain controversial. Among the many studies which have investigated the issue of dementia in Parkinson's disease, the perspectives differ widely depending upon whether the approach is that of observational clinical studies, pathological analysis, or sensitive assessment of cognitive function with neuropsychological testing. Consensus has emerged, however, that Parkinson's disease is a heterogeneous disorder both clinically and pathologically. Increasingly, interest has focused on determining whether there are subgroups of patients with Parkinson's disease who are more likely to suffer from dementia and to understand better the pathophysiology of cognitive impairment. In general, patients who present with Parkinsonian symptoms later in life, especially those in whom bradykinesia and akinesia are dominant symptoms, are more likely to become demented than are young individuals who present with tremor as the dominant symptom. However, it would be misleading to conclude that there are two distinct subpopulations of Parkinsonian patients, those who become demented and those who do not. Systematic neuropsychological studies in large populations of Parkinson's disease patients reveal that impairments of cognitive function form a spectrum ranging from very mild to very severe.[8]

Among that group of Parkinson's disease patients in whom severe dementia ultimately becomes manifest, coexistent degeneration of the cerebral cortex is commonly found.[9, 10] In the age of current therapy, patients with Parkinson's disease not infrequently live to an advanced age. Some authorities have argued that coexistent Alzheimer's disease is inevitable, and that this coincidental association of two common diseases accounts for the phenomena of severe dementia in Parkinson's disease. There is not unanimous agreement, however, on this theory.

Although severe cortical degeneration, similar to Alzheimer's disease, is common in Parkinson's disease, it has recently been found that significant mental deficiency can occur in Parkinson's disease in the absence of histological abnormalities in the cortex.[11] These observations have led to the concept of "subcortical dementia," which postulates that the basal ganglia play an important role in higher mental functions and that their involvement by disease can produce a dementia which is clinically distinct from the cortical dementia such as occurs in Alzheimer's disease.[15, 16] The validity of this dichotomy between cortical and subcortical dementias has recently been challenged.[12]

Controlled studies have failed to reveal consistent clinical differences in the dementias due to cortical and subcortical diseases.[13] A classification of dementias as cortical and subcortical based on histopathology can be misleading. As the neurobiochemical basis of dementias came under study in the late 1970s, the boundaries between cortical and subcortical dementias became much less clear. Alzheimer's disease, the prototype of cortical dementias, was found also to involve degeneration in a subcortical structure, the nucleus basalis of Meynert, which lies beneath the globus pallidus of the basal ganglia. This nuclear group deploys the neurotransmitter acetylcholine and is the chief source of this neurotransmitter to the entire cerebral cortex. Studies which related clinical dementia with histopathology and biochemical analysis revealed that the degree of dementia was more closely related to degeneration in the nucleus basalis, with resultant loss of acetylcholine, than to the severity of histological changes in the cerebral cortex. Very recently, the same neurochemical approach has been pursued in investigating the dementia of Parkinson's disease. Degeneration of acetylcholinergic neurons in the nucleus basalis was also identified and found to relate quite well to the degree of dementia in the patients studied. Thus, it appears quite possible that the dementia of Parkinson's disease and that of Alzheimer's disease may relate to degeneration of the subcortical nucleus basalis with resulting acetylcholine deficiency.[14, 15]

Conclusions

Parkinson's disease is a heterogeneous disorder both pathologically and neurochemically and its clinical manifestations in individual patients can be quite diverse. Psychiatric problems, dementia, and subtle cognitive impairment can occur commonly. While the pathophysiology of these disorders remains poorly understood and the subject of intense continuing investigation, the practitioner must maintain an awareness of the associated mental disorders accompanying Parkinson's disease.

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Delayed or immediate nerve repair to restore facial function following surgery are equally effective, according to a study from the Mayo Clinic that appears in the December 1985 issue of the *Archives of Otolaryngology*. Doctor John C. Ellis and Thomas C. McCaffrey conducted animal experiments to resolve a controversy in the discipline. "None of the physiologic parameters studied produced data to suggest that delaying repair of nerve defects for two weeks significantly changed the functional result," they say. The finding validates current practice, but suggests that delayed repair, to allow wound contamination healing, for example, also would be an acceptable mode of treatment.

• • •

Individuals who want to eat healthfully can incorporate fast food into a balanced diet by varying their fast food selections, choosing menu items that contribute to nutrient needs, and choosing meals of appropriate calorie content, according to the new report, *Fast Food and the American Diet*, published by the American Council on Science and Health. The Council is an independent, nonprofit consumer education organization promoting scientifically balanced evaluations of food, chemicals, the environments, and health.

"Many people think that the foods served in fast food restaurants are substantially different in content and nutritional value from similar foods served at home. But, in fact, it is the speed and style of service rather than the food itself which distinguishes fast food restaurants from others. It might be more accurate to refer to fast food as 'fast-service' food," said ACSH Executive Director Elizabeth M. Whelan. "Some of the nutritional limitatons of fast food are inherent in the fast-service concept," Doctor Whelan added. "To keep service speedy," she continues, "menus are kept short. This limits the variety of foods available. Since variety is important for good nutrition, meals eaten at fast-service restaurants should be incorporated into a diet that includes many other types of food."

The addition of salad bars to many fast food restaurant menus has increased the available sources of vitamins A and C and dietary fiber and has made it easier for individuals on low-calorie, low-sodium, or low-fat diets to select fast food meals that meet their special needs, the ACSH

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report notes. Consumers who are observing special dietary restrictions, however, should not assume that everything at the salad bar is suitable for them, the report warns. They need to choose salad ingredients and dressings wisely. Moreover, because the diets of many Americans, especially women and adolescent girls, do not meet the recommended allowance for calcium, the report recommends that fast food restaurants offer low-fat or skim milk, which has all the calcium of whole milk but fewer calories.

• • •

The American College of Emergency Physicians (ACEP) now has one of the most accurate listings of ambulatory care centers in the country. The result of a major research project conducted by the College, the listing is updated monthly and offers access to a rapidly growing market in the health care industry. The listing is available for purchase in the form of a roster or labels, provided the purchaser obtains ACEP approval of the material intended for distribution. Moreover, purchasers must agree not to reproduce the list in any manner, or use the list for distribution of any materials other than those approved in the request for labels. The cost for either labels or the roster is $150 for commercial distributors and $110 for educational programs approved by the College. For additional information, call or write Shirley Ahlin in the ACEP Practice Management Department, PO Box 619911, Dallas, Texas 75261 (214/659-0911).

• • •

G.D. Searle & Company recently announced that its new prostaglandin drug Cytotec® (mioprostol) has been approved by health authorities in Portugal and Venezuela. A total of eight countries have now approved the drug's use in treating duodenal and gastric ulcers. An original development of Searle research, Cytotec is the only therapeutic agent that inhibits gastric acid secretion and strengthens the stomach's natural defenses against inflammation and injury, utilizing multiple mechanisms to combat ulcer disease. Cytotec is the first prostaglandin drug available for treatment of this disorder.

Ulcers afflict an estimated 10 to 20 per cent of the world's population during a lifetime. The worldwide market for anti-ulcer drugs was estimated to be more than $1.5 billion in sales in 1984.

Additional programs are under way to evaluate the effectiveness of the drug in treatment of

other gastrointestinal disorders, such as gastritis, stress ulcers, acute upper gastrointestinal bleeding, and symptoms associated with bile reflux, and in preventing the ulcerogenic effects of chronic aspirin and other non-steroidal anti-inflammatory drug therapy.

• • •

Withdrawal from cocaine abuse is markedly different from withdrawal from alcohol, barbiturate, or opiate abuse, according to a study from Yale University published in the February 1986 issue of the *Archives of General Psychiatry*. Doctors Frank H. Gawin and Herbert D. Kleber evaluated 30 consecutive, self-referred chronic cocaine users, and found that the "crash" period after cessation of cocaine use lasts from eight to 50 hours. "After the crash, the second phase began with one to five days of near-normal affective functioning and normal sleep/waking cycles, with little cocaine craving," the researchers say. Then the patients were plagued by anxiety, irritability, and times of intense boredom. During this "withdrawal" period, "they had difficulty perceiving anything other than cocaine as potentially pleasurable. The symptoms then continued from one to ten more weeks before craving decreased." A third phase, during which episodic craving for cocaine occurs, lasts for as long as 28 weeks, the researchers note. This study "confirms that cocaine abusers exhibit uniform major-depressive-like symptomatology during a circumscribed period immediately following an episode of cocaine use," they say. Methylphenidate hydrochloride and lithium carbonate assist certain patients in withdrawal, and desipramine hydrochloride has been helpful with others.

• • •

Preliminary studies from the Albert Einstein College of Medicine show that periodic intravenous gamma globin treatments restored suppressor T cells to the normal range and prevented almost all bacterial infections in some children with AIDS or AIDS-related complex. Reporting in the February 1986 issue of the *American Journal of Diseases of Children*, Doctor Asha Gupta and her colleagues say three of five children, ranging in age from six months to six years, responded positively to treatments during a period of four to 13 months. Two children, whose suppressor T cells did not return to the normal range, died from opportunistic infections several months after completion of the study.

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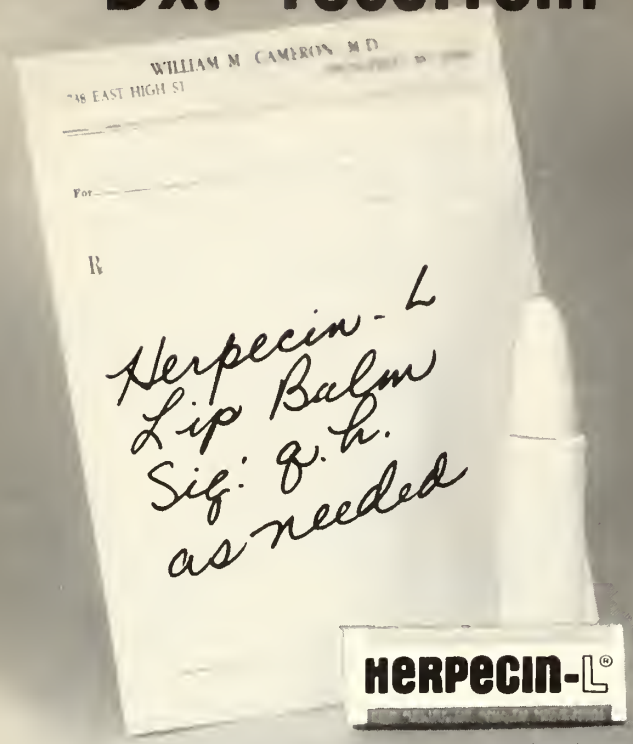
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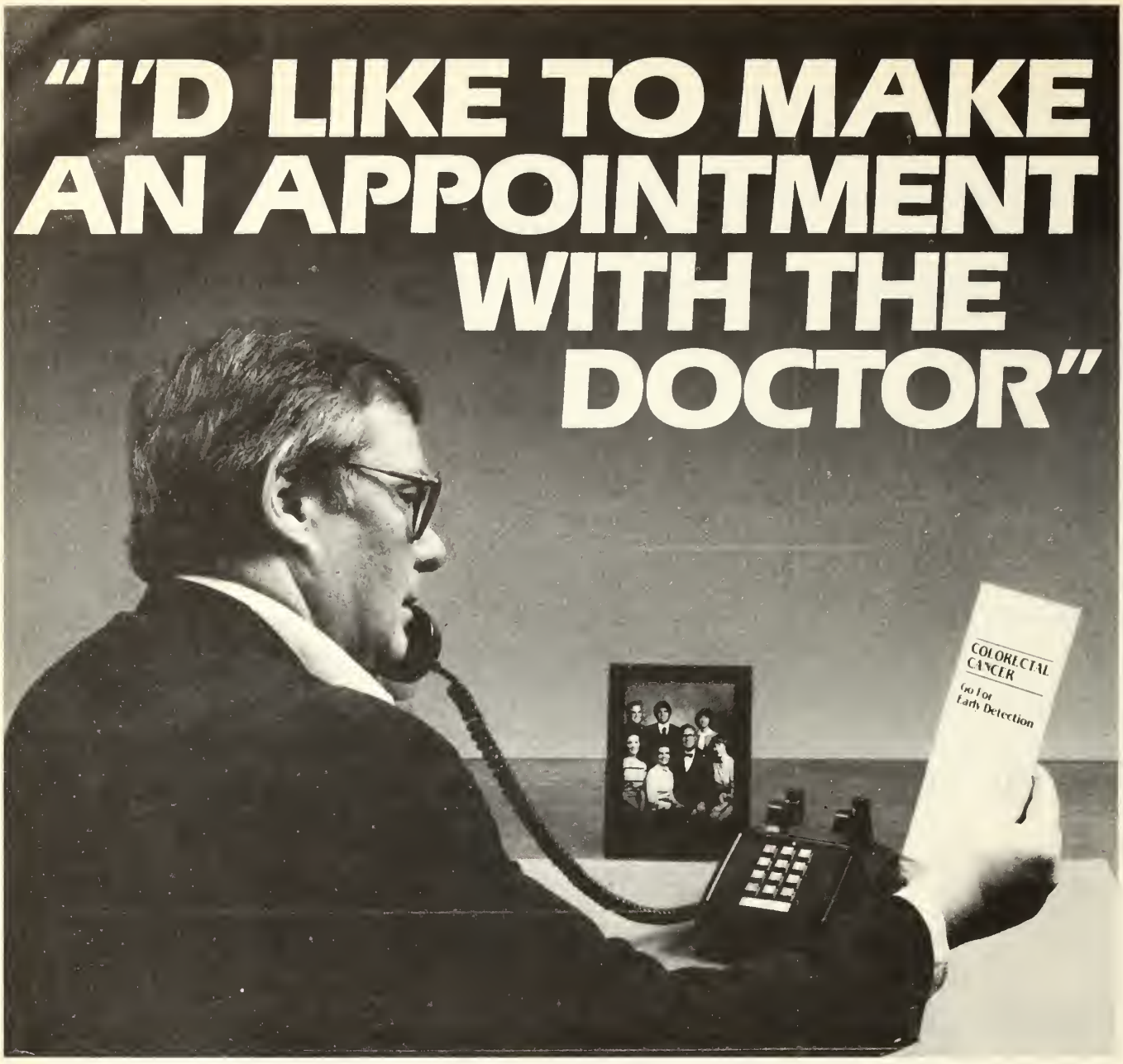
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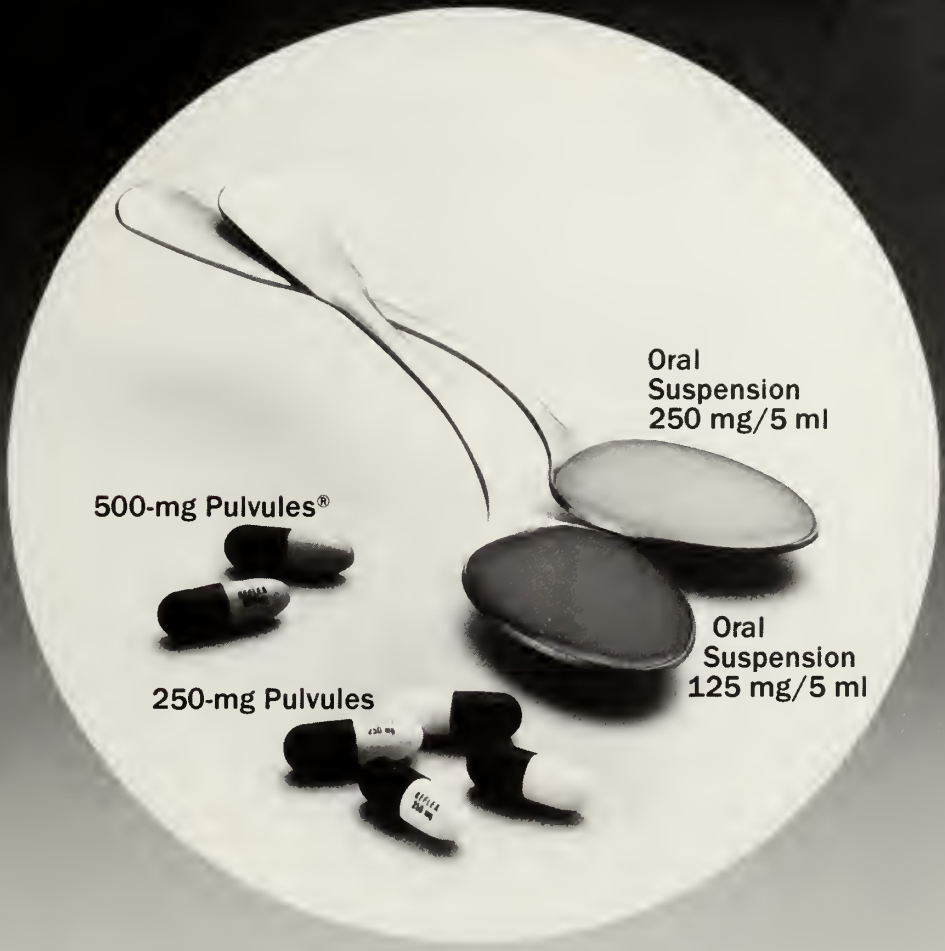
For asymptomatic persons the Society recommends annual digital rectal examination at age 40 and over; at age 50 and over, an annual stool blood test, as well as sigmoidoscopy every three to five years, following two initial annual negative sigmoidoscopies.

We're here to help. You can reach us at your local American Cancer Society office or write to our Professional Education Department at National Headquarters, 90 Park Avenue, New York, N.Y. 10016. Ask about the Society's Colorectal Check program of professional and public education for the early detection of colorectal cancer.

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*"Cancer of the Colon and Rectum: Summary of Public Attitude Survey," *Ca* 33:359-365, 1983 (Nov.-Dec.).

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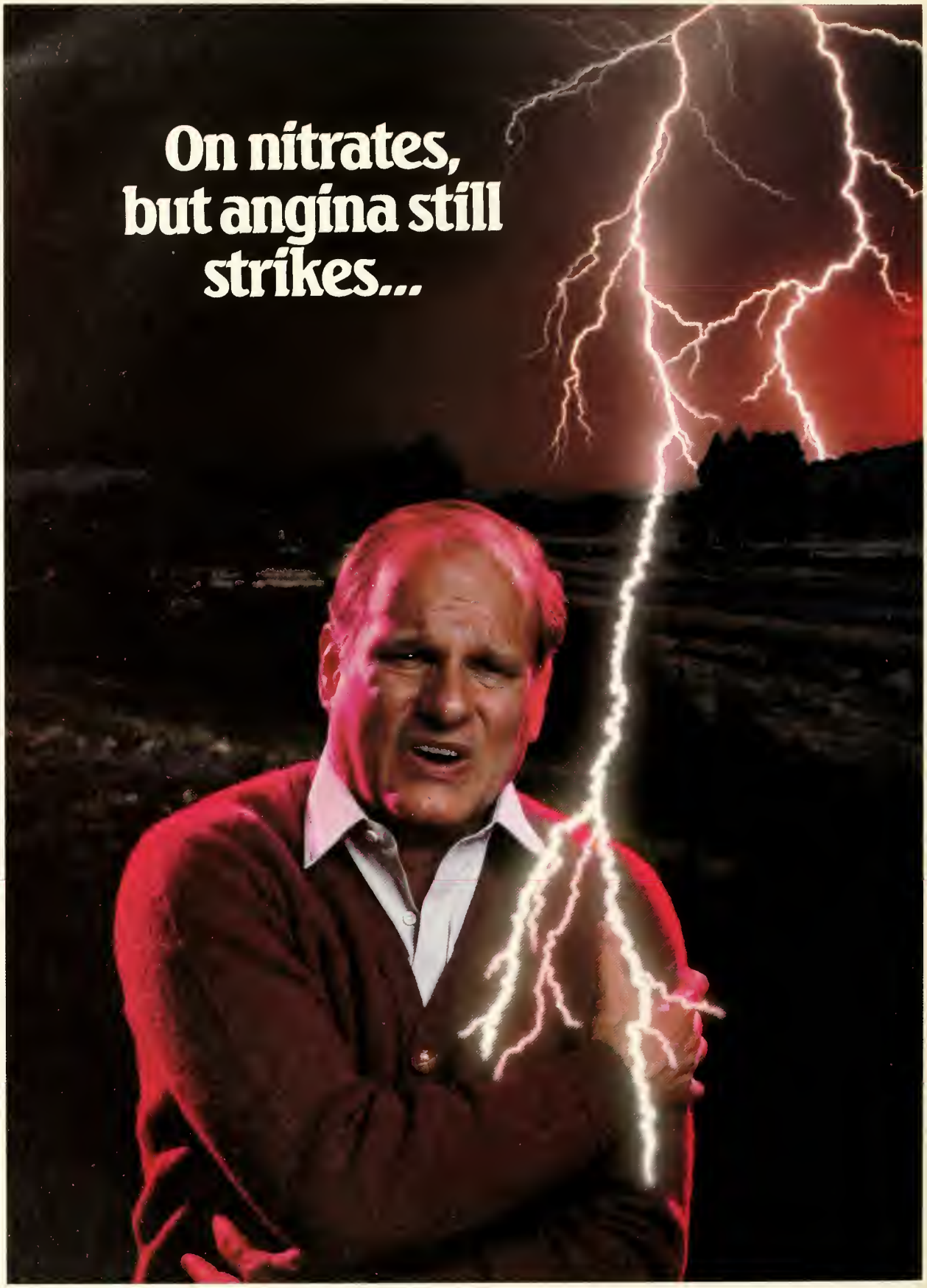
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On nitrates,
but angina still
strikes...

After a nitrate, add ISOPTIN®
(verapamil HCl/Knoll)

To protect your patients, as well as their quality of life, add Isoptin instead of a beta blocker.

First, Isoptin not only reduces myocardial oxygen demand by reducing peripheral resistance, but also increases coronary perfusion by preventing coronary vasospasm and dilating coronary arteries — both normal and stenotic. These are antianginal actions that no beta blocker can provide.

Second, Isoptin spares patients the beta-blocker side effects that may compromise the quality of life.

With Isoptin, fatigue, bradycardia and mental depression are rare. Unlike beta blockers, Isoptin can safely be given to patients with asthma, COPD, diabetes or peripheral vascular disease. Serious adverse reactions with Isoptin are rare at recommended doses; the single most common side effect is constipation (6.3%).

Cardiovascular contraindications to the use of Isoptin are similar to those of beta blockers: severe left ventricular dysfunction, hypotension (systolic pressure <90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no artificial pacemaker is present) and second- or third-degree AV block.

So, the next time a nitrate is not enough, add Isoptin... for more comprehensive antianginal protection without side effects which may cramp an active life style.



ISOPTIN. Added antianginal protection without beta-blocker side effects.

Please see brief summary on following page.

ISOPTIN®
(verapamil HCl/Knoll)
80 mg and 120 mg scored, film-coated tablets

Contraindications: Severe left ventricular dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (except in patients with a functioning artificial ventricular pacemaker), 2nd- or 3rd-degree AV block. **Warnings:** ISOPTIN should be avoided in patients with severe left ventricular dysfunction (e.g., ejection fraction < 30% or moderate to severe symptoms of cardiac failure) and in patients with any degree of ventricular dysfunction if they are receiving a beta blocker. (See *Precautions.*) Patients with milder ventricular dysfunction should, if possible, be controlled with optimum doses of digitalis and/or diuretics before ISOPTIN is used. (Note interactions with digoxin under *Precautions.*) ISOPTIN may occasionally produce hypotension (usually asymptomatic, orthostatic, mild and controlled by decrease in ISOPTIN dose). Elevations of transaminases with and without concomitant elevations in alkaline phosphatase and bilirubin have been reported. Such elevations may disappear even with continued treatment; however, four cases of hepatocellular injury by verapamil have been proven by rechallenge. Periodic monitoring of liver function is prudent during verapamil therapy. Patients with atrial flutter or fibrillation and an accessory AV pathway (e.g. W-P-W or L-G-L syndromes) may develop increased antegrade conduction across the aberrant pathway bypassing the AV node, producing a very rapid ventricular response after receiving ISOPTIN (or digitalis). Treatment is usually D.C.-cardioversion, which has been used safely and effectively after ISOPTIN. Because of verapamil's effect on AV conduction and the SA node, 1° AV block and transient bradycardia may occur. High grade block, however, has been infrequently observed. Marked 1° or progressive 2° or 3° AV block requires a dosage reduction or, rarely, discontinuation and institution of appropriate therapy depending upon the clinical situation. Patients with hypertrophic cardiomyopathy (IHSS) received verapamil in doses up to 720 mg/day. It must be appreciated that this group of patients had a serious disease with a high mortality rate and that most were refractory or intolerant to propranolol. A variety of serious adverse effects were seen in this group of patients including sinus bradycardia, 2° AV block, sinus arrest, pulmonary edema and/or severe hypotension. Most adverse effects responded well to dose reduction and only rarely was verapamil discontinued. **Precautions:** ISOPTIN should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of excessive pharmacologic effects. Studies in a small number of patients suggest that concomitant use of ISOPTIN and beta blockers may be beneficial in patients with chronic stable angina. Combined therapy can also have adverse effects on cardiac function. Therefore, until further studies are completed, ISOPTIN should be used alone, if possible. If combined therapy is used, close surveillance of vital signs and clinical status should be carried out. Combined therapy with ISOPTIN and propranolol should usually be avoided in patients with AV conduction abnormalities and/or depressed left ventricular function. Chronic ISOPTIN treatment increases serum digoxin levels by 50% to 70% during the first week of therapy, which can result in digitalis toxicity. The digoxin dose should be reduced when ISOPTIN is given, and the patients should be carefully monitored to avoid over- or under-digitalization. ISOPTIN may have an additive effect on lowering blood pressure in patients receiving oral antihypertensive agents. Disopyramide should not be given within 48 hours before or 24 hours after ISOPTIN administration. Until further data are obtained, combined ISOPTIN and quinidine therapy in patients with hypertrophic cardiomyopathy should probably be avoided, since significant hypotension may result. Clinical experience with the concomitant use of ISOPTIN and short- and long-acting nitrates suggest beneficial interaction without undesirable drug interactions. Adequate animal carcinogenicity studies have not been performed. One study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. *Pregnancy Category C*: There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor and delivery only if clearly needed. It is not known whether verapamil is excreted in breast milk; therefore, nursing should be discontinued during ISOPTIN use. **Adverse Reactions:** Hypotension (2.9%), peripheral edema (1.7%), AV block: 3rd degree (0.8%), bradycardia: HR < 50/min (1.1%), CHF or pulmonary edema (0.9%), dizziness (3.6%), headache (1.8%), fatigue (1.1%), constipation (6.3%), nausea (1.6%), elevations of liver enzymes have been reported. (See *Warnings*.) The following reactions, reported in less than 0.5%, occurred under circumstances where a causal relationship is not certain: ecchymosis, bruising, gynecomastia, psychotic symptoms, confusion, paresthesia, insomnia, somnolence, equilibrium disorder, blurred vision, syncope, muscle cramp, shakiness, claudication, hair loss, macules, spotty menstruation. **How Supplied:** ISOPTIN (verapamil HCl) is supplied in round, scored, film-coated tablets containing either 80 mg or 120 mg of verapamil hydrochloride and embossed with "ISOPTIN 80" or "ISOPTIN 120" on one side and with "KNOLL" on the reverse side. Revised August, 1984. 2385

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EXCERPTS FROM A SYMPOSIUM
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After 15 years, the experts still concur about the continuing value of Dalmane (flurazepam HCl/ Roche). It provides sleep that satisfies patients... and the wide margin of safety that satisfies you.

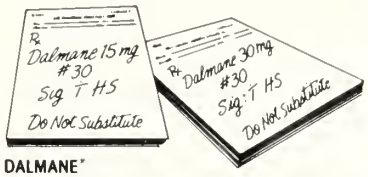
The recommended dose in elderly or debilitated patients is 15 mg. Contraindicated in pregnancy.

DALMANE®
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flurazepam HCl/Roche Ⓡ
sleep that satisfies

15-mg/30-mg
capsules



References: **1.** Kales J, *et al: Clin Pharmacol Ther 12* 691-697, Jul-Aug 1971 **2.** Kales A, *et al. Clin Pharmacol Ther 18* 356-363, Sep 1975 **3.** Kales A, *et al. Clin Pharmacol Ther 19*:576-583, May 1976 **4.** Kales A, *et al Clin Pharmacol Ther 32*:781-788, Dec 1982 **5.** Frost JD Jr, DeLucchi MR. *J Am Geriatr Soc 27*:541-546, Dec 1979 **6.** Dement WC, *et al: Behav Med*, pp 25-31, Oct 1978 **7.** Kales A, Kales JD: *J Clin Psychopharmacol 3* 140-150, Apr 1983 **8.** Tennant FS, *et al.* Symposium on the Treatment of Sleep Disorders, Teleconference, Oct 16, 1984 **9.** Greenblatt DJ, Allen MD, Shader RI. *Clin Pharmacol Ther 21* 355-361, Mar 1977



DALMANE®
brand of
flurazepam HCl/Roche Ⓡ

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening, in patients with recurring insomnia or poor sleeping habits, in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

Contraindications: Known hypersensitivity to flurazepam HCl, pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patients to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Withdrawal symptoms rarely reported, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase, and paradoxical reactions, *e.g.* excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect. *Adults*: 30 mg usual dosage, 15 mg may suffice in some patients. *Elderly or debilitated patients*: 15 mg recommended initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

ROCHE®
Roche Products Inc.
Manati, Puerto Rico 00701

#1 FOR SLEEP

After more than 15 years of use, it's #1 for sleep that satisfies. Patients are satisfied because they fall asleep fast and stay asleep till morning.[1-8] And *you're* satisfied by the exceptionally wide margin of safety.[7-9] As always, caution patients about driving or drinking alcohol.

Please see preceding page for summary of product information.

DALMANE®
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sleep that satisfies



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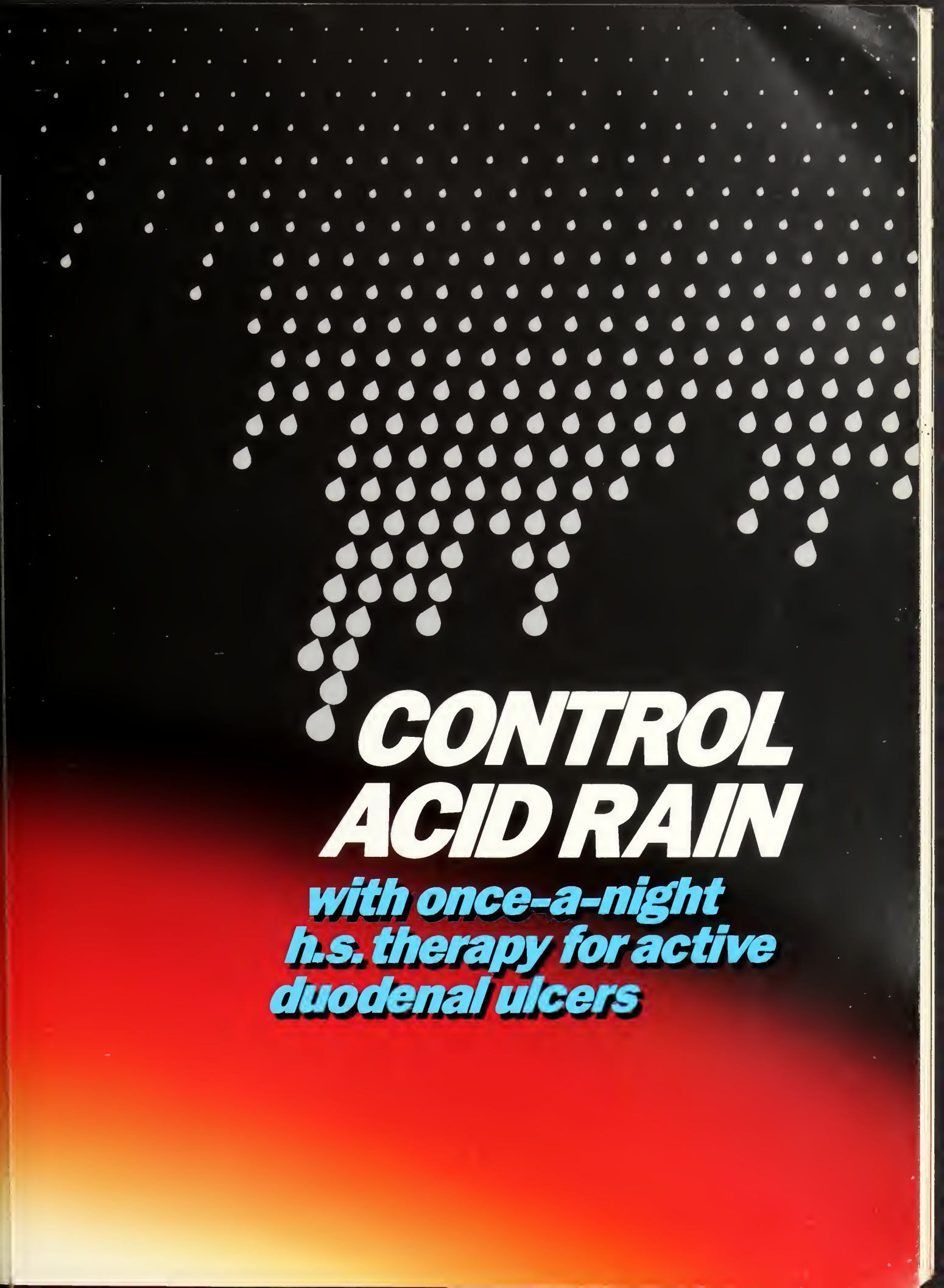
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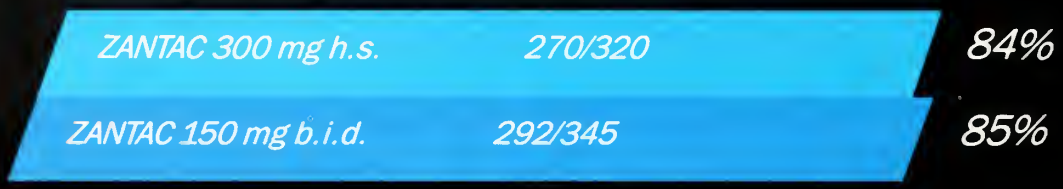
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CONTROL
ACID RAIN
with once-a-night
h.s. therapy for active
duodenal ulcers

Now, one tablet at bedtime

Controls nocturnal acid to relieve pain and heal duodenal ulcers

Heals active duodenal ulcers after 4 weeks in most patients*[1]



In well-controlled, double-blind, multicenter trials, ZANTAC 300 mg h.s. healed active duodenal ulcers in 84% of patients after 4 weeks. After 8 weeks, healing rates may be higher with ZANTAC 150 mg b.i.d. (92%) than with ZANTAC 300 mg h.s. (87%).

***Relieves pain and other symptoms as effectively as ZANTAC 150 mg b.i.d.*[1]**

Zantac® 300

ranitidine HCl/Glaxo 300 mg tablets

Once-daily dosing may enhance compliance in patients for whom dosing convenience is important

Side-effects profile comparable to ZANTAC 150 mg b.i.d.[1-3]

Headache—sometimes severe—has been reported. Rare effects on the CNS, cardiovascular, GI, hepatic, and integumental systems have been observed, as well as rare cases of hypersensitivity reactions. See ADVERSE REACTIONS section of Brief Summary of Product Information before prescribing.

No significant interference with the hepatic cytochrome P-450 enzyme system at recommended doses

ZANTAC 300 mg h.s. had no significant drug interactions with theophylline or warfarin. The bioavailability of certain medications whose absorption is dependent on a low gastric pH may be altered when ZANTAC or other medications which decrease gastric acidity are administered.



*It is not known exactly how much acid inhibition is needed to heal ulcers.

Glaxo / ROCHE

See next page for references and Brief Summary of Product Information.

IN ACTIVE DUODENAL ULCERS

Once-a-night h.s. therapy controls acid rain

Zantac® 300
ranitidine HCl/Glaxo 300 mg tablets

References: 1. Data available on request, Glaxo Inc. **2.** Ireland A, Colin-Jones DG, Gear P, et al: Ranitidine 150 mg twice daily vs 300 mg nightly in treatment of duodenal ulcers. *Lancet* 1984;2:274-275. **3.** Colin-Jones DG, Ireland A, Gear P, et al: Reducing overnight secretion of acid to heal duodenal ulcers. *Am J Med* 1984; 77 (suppl 58):116-122.

ZANTAC® 150 Tablets
(ranitidine hydrochloride)
ZANTAC® 300 Tablets
(ranitidine hydrochloride)

BRIEF SUMMARY OF PRODUCT INFORMATION

INDICATIONS AND USAGE: ZANTAC® is indicated in:
1. Short-term treatment of active duodenal ulcer. Most patients heal within four weeks. Studies available to date have not assessed the safety of ranitidine in uncomplicated duodenal ulcer for periods of more than eight weeks.
2. Maintenance therapy for duodenal ulcer patients at reduced dosage after healing of acute ulcers. No placebo-controlled comparative studies have been carried out for periods of longer than one year.
3. The treatment of pathological hypersecretory conditions (eg, Zollinger-Ellison syndrome and systemic mastocytosis).
4. Short-term treatment of active, benign gastric ulcer. Most patients heal within six weeks and the usefulness of further treatment has not been demonstrated. Studies available to date have not assessed the safety of ranitidine in uncomplicated, benign gastric ulcer for periods of more than six weeks.
5. Treatment of gastroesophageal reflux disease. Symptomatic relief commonly occurs within one or two weeks after starting therapy. Therapy for longer than six weeks has not been studied.

In active duodenal ulcer; active, benign gastric ulcer; hypersecretory states; and GERD, concomitant antacids should be given as needed for relief of pain.

CONTRAINDICATIONS: ZANTAC® is contraindicated for patients known to have hypersensitivity to the drug.

PRECAUTIONS: General: 1. Symptomatic response to ZANTAC® therapy does not preclude the presence of gastric malignancy.
2. Since ZANTAC is excreted primarily by the kidney, dosage should be adjusted in patients with impaired renal function (see **DOSAGE AND ADMINISTRATION**). Caution should be observed in patients with hepatic dysfunction since ZANTAC is metabolized in the liver.

Laboratory Tests: False-positive tests for urine protein with Multistix® may occur during ZANTAC therapy, and therefore testing with sulfosalicylic acid is recommended

Drug Interactions: Although ZANTAC has been reported to bind weakly to cytochrome P-450 in vitro, recommended doses of the drug do not inhibit the action of the cytochrome P-450-linked oxygenase enzymes in the liver. However, there have been isolated reports of drug interactions which suggest that ZANTAC may affect the bioavailability of certain drugs by some mechanism as yet unidentified (eg, a pH-dependent effect on absorption or a change in volume of distribution).

Carcinogenesis, Mutagenesis, Impairment of Fertility: There was no indication of tumorigenic or carcinogenic effects in lifespan studies in mice and rats at doses up to 2,000 mg/kg/day.

Ranitidine was not mutagenic in standard bacterial tests (*Salmonella, E coli*) for mutagenicity at concentrations up to the maximum recommended for these assays.

In a dominant lethal assay, a single oral dose of 1,000 mg/kg to male rats was without effect on the outcome of two matings per week for the next nine weeks.

Pregnancy: ***Teratogenic Effects: Pregnancy Category B:*** Reproduction studies have been performed in rats and rabbits at doses up to 160 times the human dose and have revealed no evidence of impaired fertility or harm to the fetus due to ZANTAC. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers: ZANTAC is secreted in human milk. Caution should be exercised when ZANTAC is administered to a nursing mother.

Pediatric Use: Safety and effectiveness in children have not been established.

Use in Elderly Patients: Ulcer healing rates in elderly patients (65 to 82 years of age) were no different from those in younger age groups. The incidence rates for adverse events and laboratory abnormalities were also not different from those seen in other age groups.

ADVERSE REACTIONS: The following have been reported as events in clinical trials or in the routine management of patients treated with oral ZANTAC®. The relationship to ZANTAC therapy has been unclear in many cases. Headache, sometimes severe, seems to be related to ZANTAC administration.

Central Nervous System: Rarely, malaise, dizziness, somnolence, insomnia, and vertigo. Rare cases of reversible mental confusion, agitation, depression, and hallucinations have been reported, predominantly in severely ill elderly patients.

Cardiovascular: Rare reports of tachycardia, bradycardia, and premature ventricular beats.

Gastrointestinal: Constipation, diarrhea, nausea/vomiting, and abdominal discomfort/pain.

Hepatic: In normal volunteers, SGPT values were increased to at least twice the pretreatment levels in 6 of 12 subjects receiving 100 mg qid IV for seven days, and in 4 of 24 subjects receiving 50 mg qid IV for five days. With oral administration there have been occasional reports of reversible hepatitis, hepatocellular or hepatocanalicular or mixed, with or without jaundice.

Musculoskeletal: Rare reports of arthralgias.

Hematologic: Rare reports of reversible leukopenia, granulocytopenia, thrombocytopenia, and pancytopenia.

Endocrine: Controlled studies in animals and man have shown no stimulation of any pituitary hormone by ZANTAC and no antiandrogenic activity, and cimetidine-induced gynecomastia and impotence in hypersecretory patients have resolved when ZANTAC has been substituted. However, occasional cases of gynecomastia, impotence, and loss of libido have been reported in male patients receiving ZANTAC, but the incidence did not differ from that in the general population.

Integumental: Rash, including rare cases suggestive of mild erythema multiforme, and, rarely, alopecia.

Other: Rare cases of hypersensitivity reactions (eg, bronchospasm, fever, rash, eosinophilia) and small increases in serum creatinine.

OVERDOSAGE: There is no experience to date with deliberate overdosage. The usual measures to remove unabsorbed material from the gastrointestinal tract, clinical monitoring, and supportive therapy should be employed.

Studies in dogs receiving doses of ZANTAC® in excess of 225 mg/kg/day have shown muscular tremors, vomiting, and rapid respiration. Single oral doses of 1,000 mg/kg in mice and rats were not lethal. Intravenous LD_{50} values in rat and mouse were 83 and 77 mg/kg, respectively.

DOSAGE AND ADMINISTRATION: Dosage Adjustment for Patients with Impaired Renal Function: On the basis of experience with a group of subjects with severely impaired renal function treated with ZANTAC®, the recommended dosage in patients with a creatinine clearance less than 50 ml/min is 150 mg every 24 hours. Should the patient's condition require, the frequency of dosing may be increased to every 12 hours or even further with caution. Hemodialysis reduces the level of circulating ranitidine. Ideally, the dosage schedule should be adjusted so that the timing of a scheduled dose coincides with the end of hemodialysis.

HOW SUPPLIED: ZANTAC® 150 Tablets (ranitidine hydrochloride equivalent to 150 mg of ranitidine) are white tablets embossed with "ZANTAC 150" on one side and "Glaxo" on the other. They are available in bottles of 60 tablets (NDC 0173-0344-42) and unit dose packs of 100 tablets (NDC 0173-0344-47).

ZANTAC® 300 Tablets (ranitidine hydrochloride equivalent to 300 mg of ranitidine) are yellow, capsule-shaped tablets embossed with "ZANTAC 300" on one side and "Glaxo" on the other. They are available in bottles of 30 (NDC 0173-0393-40) and unit dose packs of 100 tablets (NDC 0173-0393-47).

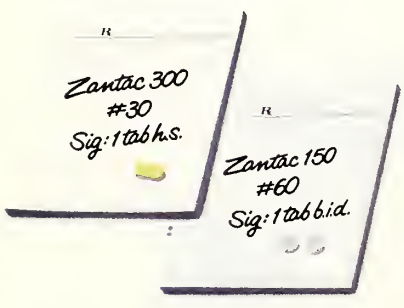
Store between 15° and 30°C (59° and 86°F) in a dry place. Protect from light. Replace cap securely after each opening.

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Glaxo

Glaxo Inc.
Research Triangle Park, NC 27709

Now...two effective regimens to treat active duodenal ulcers



In Hypertension*... When You Need to Conserve K+

Remember the Unique Red and White Capsule: Your Assurance of SK&F Quality

Serum K^+ and BUN should be checked periodically (see Warnings and Precautions).



Before prescribing, see complete prescribing information in SK&F CO. literature or *PDR*. The following is a brief summary.

* **WARNING**

This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Contraindications: Concomitant use with other potassium-sparing agents such as spironolactone or amiloride. Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

Precautions: The bioavailability of the hydrochlorothiazide component of 'Dyazide' is about 50% of the bioavailability of the single entity. Theoretically, a patient transferred from the single entities of triamterene and hydrochlorothiazide may show an increase in blood pressure or fluid retention. Similarly, it is also possible that the lesser hydrochlorothiazide bioavailability could lead to increased serum potassium levels. However, extensive clinical experience with 'Dyazide' suggests that these conditions have not been commonly observed in clinical practice. Angiotensin-converting enzyme (ACE) inhibitors can elevate serum potassium; use with caution with 'Dyazide'. Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids, and during concurrent use with amphotericin B or corticosteroids or corticotropin [ACTH]). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Cumulative effects of the drug may develop in patients with impaired renal function. Thiazides should be used with caution in patients with impaired hepatic function. They can precipitate coma in patients with severe liver disease. Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic and hemolytic anemia have been reported with thiazides. Thiazides may cause manifestation of latent diabetes mellitus. The effects of oral anticoagulants may be decreased when used concurrently with hydrochlorothiazide; dosage adjustments may be necessary. Clinically insignificant reductions in arterial responsiveness to norepinephrine have been reported. Thiazides have also been shown to increase the paralyzing effect of nondepolarizing muscle relaxants such as tubocurarine. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. Triamterene has been found in renal stones in association with the other usual calculus components. Therefore, 'Dyazide' should be used with caution in patients with histories of stone formation. A few occurrences of acute renal failure have been reported in patients on 'Dyazide' when treated with indomethacin. Therefore, caution is advised in administering nonsteroidal anti-inflammatory agents with 'Dyazide'. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia is uncommon with 'Dyazide', but should it develop, corrective measures should be taken such as potassium supplementation or increased dietary intake of potassium-rich foods. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Concurrent use with chlorpropamide may increase the risk of severe hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function. Thiazides may add to or potentiate the action of other antihypertensive drugs. Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances; postural hypotension (may be aggravated by alcohol, barbiturates, or narcotics). Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and respiratory distress including pneumonitis and pulmonary edema, transient blurred vision, sialadenitis, and vertigo have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components. Rare incidents of acute interstitial nephritis have been reported. Impotence has been reported in a few patients on 'Dyazide', although a causal relationship has not been established.

Supplied: 'Dyazide' is supplied as a red and white capsule, in bottles of 1000 capsules; Single Unit Packages (unit-dose) of 100 (intended for institutional use only); in Patient-Pak™ unit-of-use bottles of 100.

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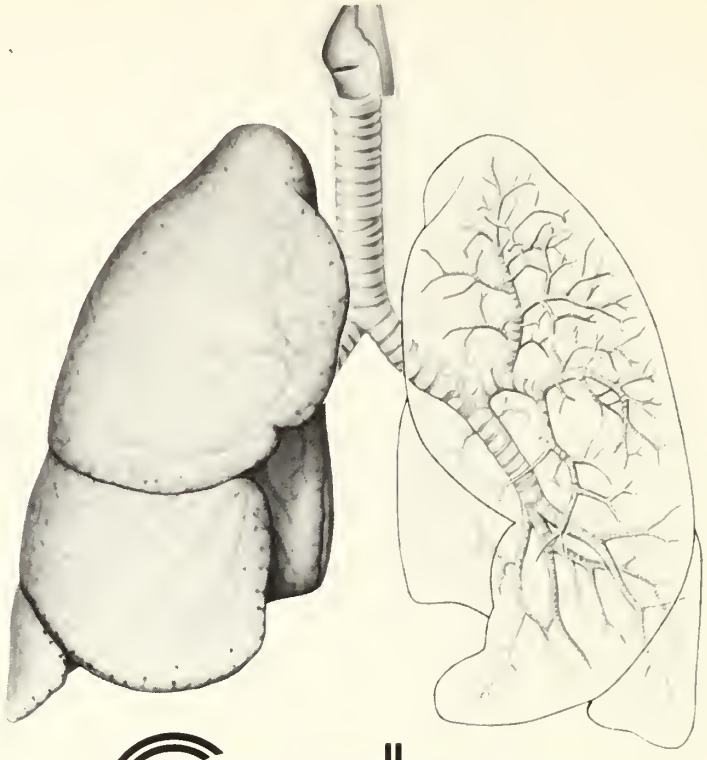
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- In renal impairment, safe dosage of Ceclor may be lower than that usually recommended. Ceclor should be administered with caution in such patients.
- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.

Adverse Reactions: (percentage of patients)

Therapy-related adverse reactions are uncommon. Those reported include:

- Gastrointestinal (mostly diarrhea): 2.5%.
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
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- Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.
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Newsletter

RHODE ISLAND MEDICAL SOCIETY
August 1986

Peter D.T. Clarisse, MD, President
Wendy J. Smith, Editor

LEGISLATIVE SCORECARD
GENERAL ASSEMBLY ADJOURNS

The Rhode Island General Assembly finally adjourned June 25 after a session fraught with controversy and debate over malpractice reform and mandatory Medicare assignment. More than 100 bills affecting the practice of medicine were introduced during the session. Because of the significance of many of these proposals, this newsletter will focus on the following summary of legislative activity:

AIDS (Acquired Immune Deficiency Syndrome)

H 8161 (DeLorenzo) - would require hospitalized AIDS patients to wear an identification bracelet. RIMS position: Oppose Status: Dead

Alcoholism treatment

S 2484 (Badeau) - would permit patients to seek treatment for alcoholism in an approved public treatment facility only once every two years. RIMS position: Oppose. Status: Dead

Confidentiality of medical information

H 8049 (Gorham et al) - would permit the release of information pertaining to the diagnosis and treatment of alcoholism without patient consent under certain circumstances. RIMS position: Oppose Status: Dead

S 2682 as amended (Lederberg) - would restore the essence of the legal process section of the Confidentiality of Medical Information Act. RIMS position: Support. Status: Signed into law June 26, 1986

Limited licensure

H 8041 (Gorham et al) - would eliminate the five-year limit on renewal of limited licenses for medical school faculty. RIMS position: Monitor. Status: Signed into law June 27, 1986

Medical liability and medical discipline

H 8534 Sub A (Teitz et al) - would restructure the state medical and dental disciplinary boards; would incorporate reforms supported by the Legislative Commission on Medical Malpractice and some additional changes in medical licensure and discipline. RIMS position: Support with reservations. Status: Signed into law June 26, 1986

S 2814 (Flynn, Gibbs) - would lower the rate at which prejudgment interest accrues from 12 per cent to 8 per cent; cap awards for non-economic damages at $250,000; and establish a sliding scale for attorneys' contingency fees. RIMS position: Support. Status: Dead

S 2891 Sub A as amended (Forte et al) - incorporates tort reforms introduced by the Legislative Commission on Medical Malpractice, including provisions relating to expert witnesses, frivolous suits, collateral sources, prejudgment interest, periodic payments, an accelerated court calendar, and stronger protections for peer review. It also freezes malpractice premiums until June 30, 1987, mandates a "merit-rating" plan for malpractice premiums, and establishes a 17-member commission to study the Joint Underwriting Association. RIMS position: Support. Status: Signed into law June 26, 1986

S 3012 (Goldberg et al) - would restructure the Board of Medical Review. RIMS position: Oppose. Status: Dead

Medicare assignment

H 7008 (DeLuca) - would require participating hospitals and physicians to accept Medicare assignment as payment in full. RIMS position: Oppose. Status: Dead

LEGISLATIVE SCORECARD

H 7148 (Cardente, McEntee) - would require physicians to accept Medicare assignment. RIMS position: Oppose. Status: Dead

H 7943 (Sherman) - would expand the statutory definition of physician "unprofessional conduct" to include failure to accept Medicare assignment. RIMS position: Oppose Status: Dead

H 7982 Sub A as amended (Sherman) - would require physicians to accept Medicare assignment as a condition of licensure. RIMS position: Oppose. Status: Dead

H 8102 Sub A (Sherman) - would require osteopaths to accept Medicare as a condition of licensure. RIMS position: Oppose Status: Dead

S 2103 (Marciano) - would require physicians to accept Medicare assignment. RIMS position: Oppose. Status: Dead

Optometrists

H 8527 (Ferry) - would require that optometrists who perform the same services as ophthalmologists be held to the same standards of care. RIMS position: Support. Status: Dead

Patient access to medical records

H 7057 (DeLuca) - would provide patients with absolute access to their medical records. RIMS position: Oppose Status: Dead

Patients on life support

H 776 (Jabour, Lafayette) - would require the names of patients on life support to be reported to the Rhode Island Department of Health. RIMS position: Oppose Status: Dead

Peer review records

H 8288 (DeAngelis) - would make the records of medical peer review committees discoverable in litigation. RIMS position: Oppose Status: Dead

Rights of the terminally ill

H 7724 (Carcieri et al) - creates durable power of attorney for health care decisions. RIMS position: Support. Status: Signed into law June 24, 1986

H 7729 (Suteel et al) - would create a living will mechanism for Rhode Island. RIMS position: Support. Status: Dead

S 2284 (Sabatini et al) - would create a living will mechanism. RIMS position: Support. Status: Dead

S 2311 (Farnum et al) - would create a living will mechanism. RIMS position: Support. Status: Dead

Seat belts

H 7049 (Gorham) - would require the use of seat belts in passenger cars. RIMS position: Support. Status: Dead

H 8221 (Gorham et al) - would require the use of seat belts in passenger cars. RIMS position: Support. Status: Dead

Smoking

H 7756 (Carcieri et al) - would restrict smoking in the workplace. RIMS position: Support. Status: Dead

S 2643 as amended (Basso et al) - would restrict smoking in the workplace. RIMS position: Support. Status: Signed into law June 27, 1986

S 2722 (Lynch et al) - would prohibit smoking in all public buildings. RIMS position: Support. Status: Dead

MEDICARE FEE FREEZE EXTENDED

The Consolidated Omnibus Budget Reconciliation Act (COBRA), containing 58 Medicare-related provisions and 39 Medicaid-related provisions, was signed into law last April. Included in the Medicare provisions was an extension of the freeze on physician reimbursement. The specific

elements of this latest continuation of the freeze are the following:

- The freeze on Medicare reimbursement and charges for non-participating physicians has been continued through December 31, 1986. Non-participating physicians are those who do not enter into a formal agreement to accept the Medicare "approved amount" as payment in full for all Medicare beneficiaries.

- The freeze in customary and prevailing charge levels for participating physicians ended on May 1, 1986. The prevailing charge increase was set at the increase in the Medicare Economic Index update determined on October 1, 1985 (3.15 per cent) plus one per cent. Participating physicians, therefore, have a 4.15 per cent update advantage over non-participating physicians.

- A physician who participated in the first year of the program and who is not participating in the second was allowed a customary charge level increase that reflected the actual charges between April 1, 1984 and March 31, 1985.

- Future updates for all physician reimbursement will be made on January 1, instead of October 1.

- A new election period to make participation decisions for calendar year 1986 was available during April 1986. Participating physicians who did not cancel their agreements during that time were deemed to have automatically extended them through December 31, 1986. Future election periods will be made in November of each year.

RHODE ISLAND LEADS NATIONAL MEDICARE PARTICIPATION RATE

Nearly 28.3 per cent of the nation's physicians signed Medicare participation agreements in 1986, a figure virtually unchanged from a year ago, according to statistical comparisons prepared by the Health Care Financing Administration (HCFA).

HCFA said that nearly 138,000 physicians (a designation which includes limited-license practitioners) continued or entered into participation agreements. There were 14,781 new participants.

Currently, more than 487,000 physicians bill for Medicare. The percentage of physicians who continued to participate was extremely high (94.2 per cent).

While 1986 sign-up rates were higher in 24 states, they declined in 27 others. Alabama physicians have the highest rate of participation (63 per cent). They are followed by Rhode Island (48.1 per cent), Pennsylvania (45.6 per cent), Massachusetts (43 per cent), and Hawaii (41.7 per cent) where the percentage increased dramatically from 20.6 per cent last October. South Dakota continued to have the nation's lowest rate at 6.9 per cent.

PEACETIME DRAFT PROPOSAL DEFEATED

A proposal that would have forced health care professionals to register for a peacetime draft was defeated in the House Armed Services Committee in late June. US Representative G.V. Montgomery, who tried to attach the plan to the fiscal 1987 defense authorization, said: "Much of the credit for its defeat has to go to the American Medical Association. The AMA had doctors from different states call members of the committee to voice opposition to the registration plan."

In an effort to offer an alternative to such legislation, the AMA signed a "memorandum of understanding" with the Department of Defense (DOD), agreeing to provide the DOD with its Masterfile list of physicians in the US. According to the agreement, DOD would be allowed to use the list only in case of a national emergency. It would also be prohibited from sharing the information with other federal agencies.

The health care personnel draft plan was initially introduced as a separate bill in the Military Personnel and Compensa-

PEACETIME DRAFT PROPOSAL (continued)

tion Subcommittee of the House Armed Services Committee by Rep. Montgomery. It called for the registration of persons ages 18 to 46 who are "trained and qualified for practice or employment in any health care occupation" needed by the Armed Forces. According to the bill, violators could be fined up to $250,000, imprisoned for up to five years, or both.

HOSPICE CARE TO OFFER PROGRAM ON PALLIATIVE CARE

As part of its tenth anniversary celebration, Hospice Care of Rhode Island, in conjunction with the Brown University Program in Medicine, is sponsoring a day-long seminar on "Palliative Care in the Eighties." The meeting will be held October 15, 1986 at the Ray Conference Center, Butler Hospital.

The keynote speaker will be Doctor Michael Levy, nationally recognized as an authority on pain management. The program is designed for physicians, nurses, social workers, pharmacists, and clergymen who wish to increase their clinical knowledge and practical skills to meet more adequately the needs of the terminally ill and their families.

Three plenary sessions will address the pain management of advanced cancer, economic and social problems, and ethical issues of death and dying. Workshops will focus on terminally-ill children and their families, spiritual needs of the dying, behavioral and cognitive aspects of pain control, and the hospice concept.

For additional information, please call Janice Miller at 401/863-3337.

23 STATES ENACT TORT REFORM

Twenty-three states have passed some form of tort reform this year, according to a comprehensive survey by the National Conference of State Legislatures, issued as many of the nation's state legislatures adjourned for the summer.

The survey shows that the single most significant characteristic of this year's tort reform drive was the willingness by state legislatures to modify tort law for all civil actions generally, not just in the medical liability area.

While the effort to modify the scope of tort reform has, for the past ten years, primarily been pushed by the medical profession, this year's legislative struggle was marked by the addition of a broad coalition of businesses, cities, and associations advocating tort reform.

An April 1986 AMA survey of pending tort reform legislation showed that 40 state medical societies were working with such a broad coalition on the state level to achieve tort reform. Nationally, the AMA has joined with a group of 140 businesses, associations, organizations, and municipalities in calling for tort reform at both the state and federal level.

NEW RIMS STAFF

Jack A. Perkins will join the staff of the Rhode Island Medical Society on September as assistant executive director. In addition to assuming responsibilities for the Rhode Island Medical Journal, his primary focus will be public relations. He also will assist Doctor Newell E. Warde in implementing the Society's legislative program.

Currently legislative assistant to Senator Quentin N. Burdick (D., North Dakota), Mr. Perkins is responsible for tracking legislation and writing testimony on such issue as banking, budget, energy, housing, labor small business, and tax reform. He previously served on the Burdick campaign staff and in several capacities with the US Senate.

Mr. Perkins is a graduate of the University of Maryland.

He replaces Wendy J. Smith, who is returning to Chicago. She has served as assistant executive director and managing editor, Rhode Island Medical Journal, since January 1983.

Rhode Island Medical Journal

August 1986
Volume 69, Number 8

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Rhode Island Medical Journal is owned and published by the Rhode Island Medical Society, 106 Francis Street, Providence, Rhode Island 02903, Ph: 401 331-3207 Single copies $2.00 — Subscriptions $15.00 per year (members of the Rhode Island Medical Society — $5.00 annually). Published articles represent opinions of the authors and do not necessarily reflect the official policy of the Rhode Island Medical Society unless clearly specified. Advertisements do not imply sponsorship or endorsement by the Rhode Island Medical Society. Second class postage paid at Providence, Rhode Island and at additional mailing offices. **ISSN 0363-7913**

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Missing and Exploited Children

COVER:

RIMS in action: More than 500 physicians attended the February 5, 1986 open hearing of the Legislative Commission on Medical Malpractice to express their concerns about the impact of the malpractice crisis on their patients. For more information, see page 357.

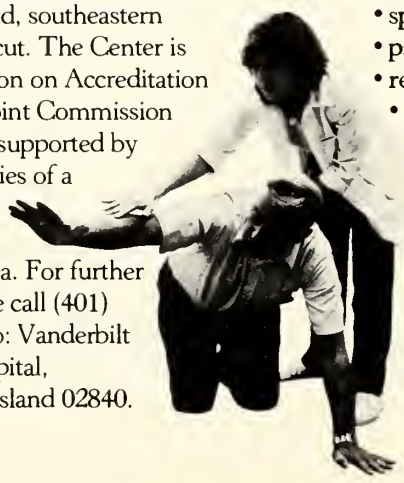


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EDITORIAL

Whither Graduate Medical Education?

While most physicians are well aware of the financial concerns being raised about medical care in the United States, the problems of funding graduate medical education are not as familiar. Federal legislation currently under consideration would reduce considerably the Medicare funds appropriated for graduate medical education. In some instances, funding for subspecialty training in internal medicine would be totally eliminated. Because graduate medical education is an integral component of quality medical care, we must work hard to assure its continued support through active lobbying of both state and federal agencies. Innovative funding methods must originate in the physician sector.

A recent dialogue between Doctors Robert Petersdorf and Edward Hook in the *Observer*, a publication of the American College of Physicians (ACP), is worth reading. Although their opinions differ slightly, they share a major concern with regard to training in internal medicine and outline their concerns well. The American College of Physicians, while supporting a five-year limit on training supported by federal sources, recommends that Medicare support graduate medical education for an appropriate number of residents in general internal medicine and the medical subspecialties. This would be consistent with what is already being done for surgical training. It would appear that at least one federal proposal would shift funds from subspecialty training in internal medicine to the surgical subspecialties. In addition to remedying this obvious inequity, the College believes that there must also be an appropriate mix of general internists and subspecialists.

ACP also recommends against using patient care revenues to fund the residency training of US and alien graduates of foreign medical schools not accredited by the Liaison Council on Medical Education. This dramatic step in restricting the postgraduate funding of US citizens who have trained abroad will affect whether these individuals are accepted into training programs. In Rhode Island we should be aware of this factor, as some of our finer physicians, many of them Rhode Island natives, were educated in foreign medical schools. The College does suggest, however, that appropriate numbers of alien foreign medical graduates who are committed to returning to their countries of origin should train in the United States, funded by sources other than Medicare.

The last point, ie, alternative funding, raises some hard questions that deserve answers. Should we find alternate sources of funding of graduate medical education in Rhode Island? Should such funding utilize non-hospital revenues such as research training grants, professional fees, medical school funds, and so forth? Should the medical school faculty be reduced to control funding? Should we diversify the support for graduate medical education, maintain stronger clinical and basic science ties, and streamline the system to improve efficiency? Should we improve hospital ambulatory facilities to compete with private practitioners for revenue? Do we need as many training programs as we have in this state? Do we need to train as many house officers? Should the number of hospital beds be reduced and graduate education scaled down? Should we favor payments toward hospitals with teaching facilities and away from nonteaching hospitals?

These are hard questions that we must address with concern, foresight, cooperation, and responsibility. Isn't it time for hospitals, state government, physicians, health care officials, and universities to arrive at a consensus?

Edward A. Iannuccilli, MD
Immediate Past Governor for Rhode Island
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PRESIDENT'S PAGE

SOC. MED. RHOD. INSTL. INST. WOONSOCKET

The Diversity of Medical Practice

The recent celebration of the Fourth of July brings to mind one of the truisms of American life. As a country, we derive considerable strength from the diversity of our citizens. Although our ancestors arrived at Ellis Island and other ports of entry with widely varying backgrounds, they were able to meld their aspirations into one common goal for a better and brighter future.

Yet the same diversity that strengthens the country is threatening to splinter the profession of medicine, according to Doctor Harrison L. Rogers, Jr. in his presidential address at the recent AMA House of Delegates meeting. Physicians must quit looking back to the good old days and the traditional practice of medicine, Doctor Rogers told the House, and unify to protect medicine as a calling, rather than merely a business. Physicians who have been in practice for many years must realize that medicine "is never again going to be what it was." Because the pace of change is going to accelerate and not diminish, we must stop talking and thinking in terms of what is traditional, look to what is new, and how we can best adapt to it.

We must stop debating issues in terms of traditional versus alternative medical practice because of its alienating effect on physicians on both sides of the debate. "There is no such thing any more as a best or even better way to practice medicine," according to Doctor Rogers. There are perfectly competent physicians practicing in solo or small partnership offices and in shopping centers as well. There are qualified physicians who are salaried employees of hospitals or members of health maintenance organizations or preferred provider organizations. Good physicians also can be found in large medical groups or in joint business ventures with hospitals.



Peter D. T. Clarisse, MD

Organized medicine will not survive unless we recognize the widely divergent needs of physicians in their quest to provide quality medical care to their patients. Regardless of their practice location, Doctor Rogers said, all physicians "are trying to learn how to take care of patients who are unable to pay for everything they need because their insurance is limited or because their government program has been cut back or simply because they have no insurance."

To meet this goal, the AMA at this year's annual meeting sponsored a forum for employed physicians to find ways in which the organization

can help them pursue their profession. Nearly 40 per cent of all young physicians are employed, and the numbers are likely to increase as a result of the mounting financial pressures of attending medical school. Three years ago, the AMA established the Hospital Medical Staff Section, which represents more than 20 per cent of all US hospitals and attracts 600 to 700 physicians to its meetings. This year the AMA House of Delegates approved formation of a new Young Physicians Section to offer physicians under age 40 a more active role in organized medicine. Currently, only 20 per cent of such physicians are AMA members. The Association hopes that by offering young physicians their own political forum, it can boost young physician membership.

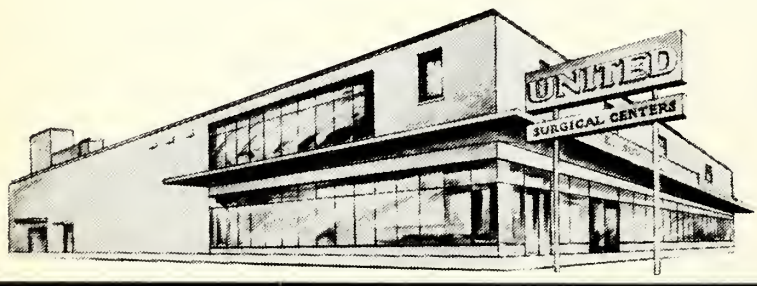
The Rhode Island Medical Society has followed the AMA's leadership role by offering to the 22 hospitals of the state delegate status in the House of Delegates. The president of the Staff Physicians Association of Rhode Island (SPARI) serves as a member of the Council. Further, we are exploring ways of meeting the practice needs of young physicians, many of whom are employed, as well as those in residency programs.

Physicians are being pressured inexorably toward a business rather than a professional approach to practice. To avoid the splintering of a proud profession, we must stop bemoaning the loss of the good old days and recognize that diversity, when properly controlled, represents strength and not weakness. It is the responsibility of organized medicine to help all physicians provide quality medical care to their patients whether they practice in a traditional office setting, in a health maintenance organization, or in a shopping center.

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SPECIAL REPORT

Public Relations and the Malpractice Crisis

During 1985 Rhode Island physicians were gearing up to seek significant changes in the medical liability system. Despite tort reforms enacted in the mid-1970s, the situation had reached crisis proportions and threatened to limit access to quality medical care. The task was an uphill battle. In the face of this serious emergency, Rhode Island newspapers carried front page stories of a physician whose license was revoked for implanting unnecessary pacemakers, another who was accused of sexually molesting several female patients, and a third who turned in his medical license to avoid disciplinary action and tried to establish a new practice in another state. These reports did not help the public's image of local physicians.

Although national polls continued to show a high acceptance rate for physicians, public approval in Rhode Island appeared to present problems. A survey commissioned by the American Medical Association and carried out in 1985 revealed that 63 per cent of Rhode Islanders complained that doctors charged too much for their services while 58 per cent believed that physicians were too interested in making money. Moreover, 50 per cent of those surveyed were of the opinion that doctors did not care about people as much as they once did while 61 per cent believed that people become physicians primarily for the money and prestige. Finally, an overwhelming 81 per cent complained that the state's doctors kept their patients waiting too long.

The Rhode Island Medical Society began to mobilize its membership to gain the support of the public, legislators, and opinion leaders to build a climate favorable to significant tort reform. To help in this effort, the Society engaged Duffy & Shanley as its public relations counsel in April 1985 to develop a public relations program and to help the Society gain support for the enactment of legislative reform.

It was determined that the Society must heighten its visibility and work to improve the image of the state's physicians. Communication between physicians and legislators, physicians and the press, and physicians and the public must be established and strengthened. Perhaps the most difficult group to convince of the need for tort reform was the general public. A plan designed to increase the visibility of physicians was implemented.

Increased Visibility

Articles, public service announcements, increased contact with members of the media, and appearances on television and radio programs were utilized in an attempt to demonstrate that Rhode Island physicians are concerned about the quality of health care in the state.

A series of six articles with by-lines on various medical topics were written by Society members and distributed to newspapers throughout the state. The articles were well received and appeared in several regional, daily, and weekly newspapers. Television and radio also were used to enhance the image of Rhode Island physicians. Public service announcements, obtained from the American Medical Association, addressed consumer health issues in an entertaining and informative manner. Spot items carrying the tag line "sponsored by the Rhode Island Medical Society" were distributed to local radio and television stations. One local television station broadcast the items a total of 64 times during February and March. Another began carrying the announcements in January and continued to do so through late spring.

The public relations counsel assisted the Society in placing members on several radio and television public affairs programs to discuss medical issues. During his presidency, Doctor Herbert Rakatansky served as spokesman for the Society, making numerous appearances on behalf of the Society. Indeed, Doctor Rakatansky became the media's favorite resource on subjects involving medicine. In July and August 1985, as an example, he appeared on local television and radio news programs to discuss colorectal cancer.

In September 1985 both Doctor Rakatansky and Doctor Kenneth E. Liffmann were interviewed about medical liability insurance on a local evening news program. In November Doctor Rakatansky appeared on two evening news programs to discuss the Society's position concerning the acceptance of assignment of Medicare benefits by physicians and full reimbursement for their services. In late November, he taped a series of programs with Lou Adler for his daily medical features on radio station WOR in New York. The programs were broadcast for a whole week in January 1986.

As the visibility of the Society increased and the medical liability insurance crisis became a more prominent issue, it was increasingly important for the Society to have effective spokespersons to represent its view to the public. To this end, Doctors Rakatansky and Liffmann participated in a media training session to prepare them for interviews with television reporters.

These efforts provided an opportunity for the physicians to share their expertise with the public in a relaxed, but professional manner and to demonstrate further their concern for the quality of health care in Rhode Island.

Laying the Foundation

It was now essential to bring to the media, the public, and the legislators the physicians' views of the medical liability insurance issue. Six position papers were researched and prepared on malpractice, peer review, the impaired physician program, physicians as patient advocates, the Rhode Island Medical Society, and the Board of Medical Review. These papers were used as a major resource in response to inquiries and for fact sheets developed as a handy reference for the media, public, legislators, and physicians.

To encourage interaction with the media, local district society presidents were asked to identify within their medical societies potential spokespersons who could discuss various medical topics in detail. This resource list was distributed to both broadcast and print media. With the assistance of public relations counsel, the Society secured the services of a lobbyist to present to the General Assembly the Society's viewpoint regarding medical liability insurance. The lobbyist set the stage for physician contact with legislators and continued to present the Society's views throughout the legislative session.

It was important at this time that the general public be informed of the Society's view of the medical liability insurance issue. A pamphlet explaining the situation and its importance to the physician, the patient, and the future of quality medical care in the state was distributed. Each member of the Society with an office practice received a package of one hundred copies. Many physicians requested more copies for distribution.

To educate the public further, a *Malpractice Alert* newsletter was published quarterly to provide timely, relevant information. It dealt exclusively with the medical liability insurance issue, designed to convey the message that the crisis, if unresolved, would seriously affect medical care in Rhode Island. It would also help to educate decision-making groups concerning the issue and elicit support for the physicians' point of view.

The first issue of *Malpractice Alert*, appearing in late fall, was distributed to more than 1,600 persons, including members of the Society and the medical specialty societies, the Hospital Association of Rhode Island, the Department of Health, the board of directors of local chambers of commerce, the General Assembly, the Rhode Island Federation of Chambers of Commerce, the Department of Business Regulation, the Rhode Island Business Group on Health, the Joint Underwriting Association, the Rhode Island Optometric Association, the Rhode Island Bar Association, and the local media.

With increased public awareness of the issue and its importance, the Society and public relations counsel began to concentrate their efforts on the General Assembly. Preparations were made for the legislative session scheduled to begin in January 1986. It also was the beginning of the investigation by the recently-appointed Legislative Commission on Medical Malpractice, with witnesses called to testify on various aspects of the issue. The next phase of the program, to gain the support of the General Assembly for tort reform, was then implemented.

Working for Reform

As the legislative session progressed, it was vital for the Society and its members to take an active stance. For too long it was believed that physicians had failed to take the initiative in expressing their views to the legislators. It was recommended that they use their strength both in numbers and in status to influence the legislative body.

A series of breakfast and dinner meetings was held by the district societies to which legislators representing the areas were invited. These in-

formal meetings provided an opportunity for physicians and legislators to know each other and to express their mutual concerns. More than 50 legislators attended these meetings.

Involvement with the Press

At this point, several Society members made further local media appearances to discuss the liability issue. An effort was made to have President Rakatansky, as the Society's chief spokesman, secure as much media exposure as possible. This included interviews by Mark Patinkin, columnist of the *Providence Journal;* former Providence Mayor Vincent A. Cianci of radio station WHJJ; and local television news personalities. Other spokespersons were also interviewed by the media to get broader exposure and to increase public understanding of such issues as peer review and no-fault insurance related to the liability insurance crisis. Maintenance of the physicians' overall visibility was an important ancillary effort. This was accomplished through signed newspaper articles, press releases, and other placements. A continuing relationship with the media was maintained to ensure that the Society's viewpoint was shared with the public.

The Turning Point

A climax of the campaign was reached in February when more than 500 physicians crowded the auditorium of the Department of Health, requiring the Malpractice Commission public hearing to be moved to the much larger Veterans' Memorial Auditorium. This excellent attendance demonstrated how concerned Rhode Island physicians were about the liability insurance crisis and the future of quality medical care. Their involvement was the key to the success of the program. Legislators and members of the Legislative Commission on Medical Malpractice were convinced by the number of physicians who took the time to attend the public hearing that something must be done about the crisis.

"Malpractice Alert" stickers were designed for the physicians to wear at the hearing. A briefing sheet outlining the testimony process was prepared and distributed. Several physicians were selected to testify about various aspects of the issue. Public relations counsel worked with these physicians to develop their testimony and to assure that all of their points were made clearly and concisely.

Decision-makers and the media were beginning to understand the full significance of the issue. Several local television stations presented programs to help inform the public about the crisis. In March, station WJAR-TV channel 10 produced an hour program about the issue, entitled, "Malpractice: Who Pays the Price?" Doctors Rakatansky and Liffmann served as panelists on the program, which was taped live using questions from a studio audience. Moreover, WLNE-TV channel 6 produced a half-hour program, "Malpractice: Who Feels the Pain?" which appeared on April 17. It featured interviews with Doctors Rakatansky and David Carter and several others.

More Work in the Future

The year's efforts were just a beginning. The Legislative Commission on Medical Malpractice submitted to the General Assembly a package containing 31 recommended reforms. Included in this package were changes in the date that interest on monetary awards will be accrued; a penalty procedure for frivolous lawsuits; consideration of mandated structured settlements for all awards exceeding $100,000; specialty board certification for all expert witnesses; and amendment of the collateral source rules eliminating dual payments. Despite these gains, the problem is by no means solved.

Physicians must continue to improve their public image by becoming more involved with the community. This can be achieved through increased participation in community service organizations, educational efforts, and financial contributions to worthy causes. Communication between physicians and legislators must continue and grow. It is important that physicians be heard on all health-related issues throughout the year and not just in times of crisis. Physicians must stay informed about issues that can and will affect the quality of health care in Rhode Island. More important than all of these measures, physicians must cultivate an image of caring among their own patients. Only by following these vital steps can real, positive changes in the image of physicians in the state be realized — a necessary step to achieve significant tort reform during the coming legislative sessions and to restrain legislation detrimental to physician-patient relations and the quality of medical care. There is no justification for relaxation of these efforts.



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Recent Research Advances in Parkinson's Disease: Part II

Studies in Lower Animals Indicate a Future for Brain Implants

Joseph Friedman, MD

The discovery of 1 methyl-4-phenyl-1,2,3,6 tetrahydropyridine (MPTP) has led to a marked increase in research interest in Parkinson's disease (PD) with increased hope for better treatment and improved understanding of the illness.[1] Another promising area of research involves an empiric approach to the problem of treatment: the use of brain implants.

Before the availability of L-dopa, the two major treatment modalities for PD were anticholinergic medications and neurosurgery. Medications had moderate usefulness early in the illness but only limited utility later on. Neurosurgery for PD involved the creation of a lesion in the thalamus stereotactically. As computed tomographic scanners were often not available until the late 1970s, these procedures were not very accurate. When successful, thalamotomy led to marked improvement in tremor and rigidity on the contralateral side. Akinesia, bradykinesia, and gait instability, however, were unaffected. Surgical complications of the procedure could be disasterous. When bilateral thalamotomies were performed, the complication rate increased dramatically with a 20 per cent chance of permanent muteness. The procedure is now rarely performed.

The problems associated with long-term L-dopa treatment were discussed in a previous paper. Their pathogenesis is not understood, but is thought to be due in part to postsynaptic receptor changes.[2,3] Some aspects of PD that we do understand suggest other reasons for the difficulties. One obvious problem with L-dopa therapy is its capacity to reach all parts of the brain, even though its beneficial effects are limited to one small region. Further, since more than 80 per cent of the zona compacta of the substantia nigra has been destroyed, and the remaining 20 per cent or less is in a hypermetabolic state producing dopamine, there is a loss of normal regulatory influences over these cells.

One of the facts that has been learned from the MPTP experience is that only the zona compacta is clinically important in causing clinical Parkinsonism. This suggests that treatment may be directed only toward improvement in zona compacta function. This concept has encouraged the present research into the use of brain implants to restore dopamine function and other zona compacta functions as well.

To understand how brain implants are used functionally, one must first understand animal models of PD. Until the recent development of the MPTP model of PD, the standard animal model for testing therapies had been the Ungerstedt preparation. Here, animals are subjected to a unilateral locally applied chemical ablation of the substantia nigra (SN). Initially the animals turn to the side of the lesion because of a deficiency of the SN outflow (dopamine). Over a period of time the animals compensate for the dopamine deficiency to some degree by developing an increased number of dopamine receptors.[4] This allows them to exhibit relatively normal behavior, but causes them to be "supersensitive" to dopaminergic drugs on the side of the lesion (Fig. 1). When such animals are given apomorphine, a potent dopamine agonist, they turn away from the side of the lesion since that side is now more reactive to the drug effects than the normal side. Amphetamine, which acts by increasing re-

Joseph Friedman, MD, is Chief of Neurology, Roger Williams General Hospital, Providence, and Assistant Professor of Medicine, Brown University Program in Medicine.

lease of catecholamines, causes ipsilateral turning since the normal side secretes dopamine while the impaired side has no dopamine to release. Observation of the number of turns in experimental animals as compared to controls in response to dopaminergic drugs is a standard method for demonstrating drug strength and severity of the lesion. Once the animal is sacrificed, standard biochemical tests may be performed to assay for dopamine, dopamine receptors, and dopamine by-products. Other tests of SN function include sensori-motor asymmetries such as spontaneous maze turning, or direction of turning in response to such stimuli as a tail pinch or whisker rubbing.

Several successful experiments have been performed in rats showing that embyronic tissue from the central mesencephalon, the area in which the substantia nigra is located, transplanted into an adult rat, will, in most cases, remain alive without the use of immunosuppressive drugs. The transplanted cells are implanted near the caudate nucleus, the region of the brain to which the substantia nigra cells project.[5-7] In these experiments, turning in response to apomorphine was reduced by 50 per cent or more in the animals which received the substantia nigra implant as compared to the controls which received only a sciatic nerve implant. Tests of sensori-motor function also showed a significant difference in transplanted as compared to non-transplanted animals. Histologic studies revealed that the grafts had survived and had actually innervated the caudate nucleus. Fluorescent antibody studies demonstrated that the implants were rich in catecholamines and serotonin. Thus, histologic and behavioral studies both demonstrated benefit from an implant.

The high acceptance of grafts without immunosuppression is an unusual feature of brain implantation. The existence of the blood-brain barrier has led to the concept of the brain being an immunologically "privileged site," with a markedly diminished tendency to rejection. The relative success of inter-species grafting in which embryonic mouse brain cells were transplanted into rats with SN-induced lesions appears to be evidence supporting this theory. There was a positive "take" histologically in ten of 18 rats, although the bulk of the graft was resorbed. In eight of these ten animals there was a behavioral response indicating a return toward normal. When studied histologically, the grafts that were not rejected appeared to innervate the caudate nucleus in a manner similar to that of the intra-

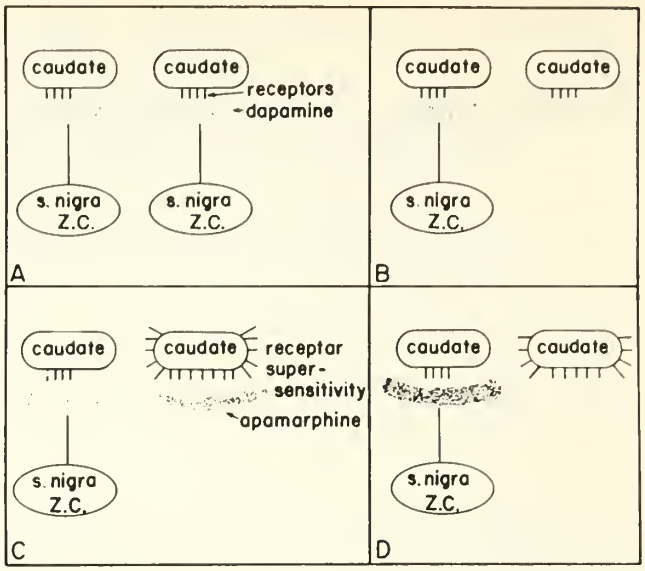


Fig 1: The classic animal model of Parkinson's disease. A — Normal control with both substantia nigras (zona compacta) and both caudate nuclei intact. B — A rat with an acute lesion has lost the dopaminergic cells in the zona compacta of the substantia nigra. The caudate is initially unaffected. C — In the chronically altered animal, the caudate nucleus on the side where the substantia nigra is destroyed develops an increased number of receptors and becomes "supersensitive." When a dopamine agonist, such as apomorphine, is given, the side with the lesion reacts more strongly than the normal side, causing the animal to turn away from the lesion to the left. D — In the chronically altered animal when amphetamine is given, the dopaminergic cells secrete more dopamine. Only the intact side can respond to the amphetamine, causing the animal to turn away from the normal, more stimulated side and to the right.

species grafts. It is possible that the graft acceptance rate can be improved with immunosuppressive drugs in future trials with human subjects.

Exploiting the pluripotential nature of adrenal chromaffin cells, investigators have explored the possibility of transplanting normal adrenal medullary tissue to the brain. The adrenal medulla synthesizes epinephrine which is released into the systemic circulation. Dopamine is a precursor, which is found in only minute quantities in these cells (Fig. 2). Since adult chromaffin cells are capable of developing into cells with characteristics of sympathetic neurons if cultured in media with nerve growth factor, it is reasonable to expect that these cells may alter their normal epinephrine production if transplanted to the brain.[9] Adrenal implants would be autografts and

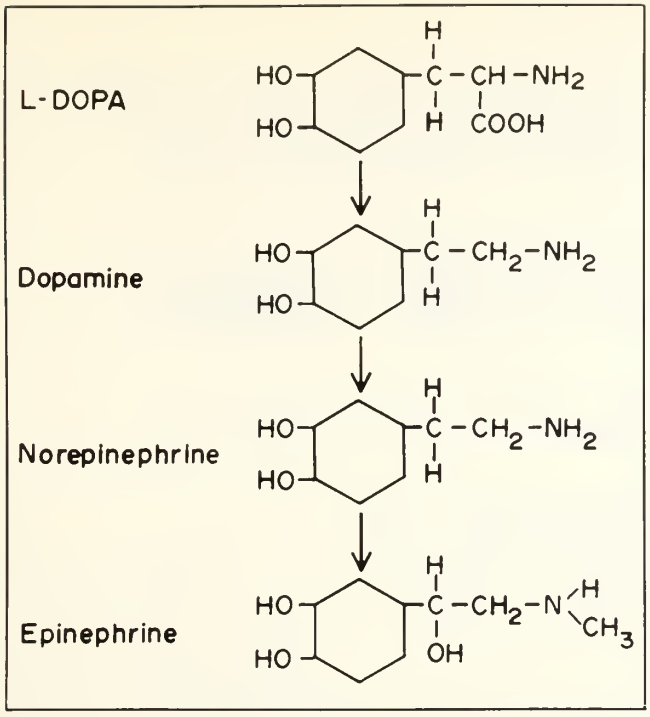


Fig 2: Pathway for synthesis of norepinephrine.

therefore not subject to rejection. Systemic function would not be compromised by the loss of one adrenal gland. Since the adrenal medulla is quite large in comparison with the zona compacta, there is more than enough tissue available. The tissue is cut into several small fragments which can be injected or placed into multiple sites around the caudate nucleus or into the lateral ventricles. This procedure can, of course, be performed bilaterally, using the cortical tissues of only one adrenal gland.

Few results have been published concerning brain implants in primates. Seven monkeys received implants at the National Institute of Mental Health. Five were from fetal substantia nigra and two from the animals' own adrenal glands. Only one of each type of graft survived.[10]

Despite the paucity of experience with adrenal implants in higher animals, physicians in Sweden stereotactically implanted adrenal medullary tissue into the caudate nucleus of two patients with severe Parkinson's Disease who had not responded to maximal medication regimens.[11] Both patients tolerated the procedure well. One showed no significant change as a result of the operation, but the second, who received a larger amount of adrenal tissue in a slightly different location, was thought to have a mild sustained improvement on smaller doses of medication. Biochemical analyses of cerebrospinal fluid were performed, but cannot be reliably interpreted. The initial samples, obtained before the resumption of L-dopa therapy, may have been taken before the grafts could be productive, while later studies were performed after the patients had resumed taking L-dopa. Clinical interpretation of these results is clearly difficult since only two cases were involved. Further, stereotactic surgery, although its target, the thalamus, is different, may itself improve PD. Also some chronically treated PD patients actually do better on L-dopa doses lower than they had used in the past. Although the human experiments were not clearly successful, there is sufficient rationale to pursue these studies.

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1) The original and one copy must be submitted by Sept. 1, 1986 to Secretary, Caleb Fiske Fund of the Rhode Island Medical Society, 106 Francis Street, Providence, Rhode Island 02903.
2) All papers must be double-spaced and should not exceed 10,000 words.
3) The award recipient must transfer copyright privileges to the Trustees of the Caleb Fiske Fund of the Rhode Island Medical Society. The paper will be considered for publication in the *Rhode Island Medical Journal*, subject to review by the Editorial Board.

RHODE ISLAND MEDICAL SOCIETY

CONSTITUTION

Effective May 30, 1986

ARTICLE 1. NAME

The name of this organization is the Rhode Island Medical Society.

ARTICLE 2. OBJECTIVES

The objectives of this Society are to promote the art and science of medicine and the improvement of public health; to advocate the provision of quality medical care for all patients; to promote the exchange of information and dialogue among physicians; and to enlighten and direct public opinion in regard to the problems of medicine.

ARTICLE 3. CONSTITUENT SOCIETIES

The constituent societies of this Society consist of those county or district medical societies which hold charters from this Society that are in full force and effect.

ARTICLE 4. MEMBERS

The Rhode Island Medical Society shall consist of members of a county or district medical society and others as provided in the Bylaws.

ARTICLE 5. HOUSE OF DELEGATES

The legislative and policy-making body of the Society is the House of Delegates composed of elected representatives and others as provided in the Bylaws. The House of Delegates shall transact all business of the Society not otherwise specifically provided for in this Constitution and Bylaws and shall elect the general officers except as otherwise provided in the Bylaws.

ARTICLE 6. OFFICERS

The officers of this Society are the President, President-Elect, Immediate Past President, Secretary, Treasurer, Speaker and Vice-Speaker of the House of Delegates, and AMA Delegate and Alternate Delegate. Their qualifications and terms of office shall be provided in the Bylaws.

ARTICLE 7. MEETINGS

The Society shall hold an annual meeting at such place and time as the President may determine. The Secretary shall give each member adequate notice as provided in the Bylaws.

A special meeting of the Society may be called by the President at his or her discretion and must be called on the written petition of 25 members.

ARTICLE 8. FUNDS

Funds for conducting the affairs of the Society may be raised: (1) by such annual dues from the members of the Society as the House of Delegates may determine; (2) by such special assessments on members as the House of Delegates may determine; (3) by voluntary contributions, devises, bequests, and other gifts; and (4) in any other manner approved by the House of Delegates.

ARTICLE 9. OFFICIAL PUBLICATION

The official publication of this Society is the *Rhode Island Medical Journal*, which shall publish all official Society notices and transactions of the House of Delegates, general meetings of the Society, and abstracts of the meetings of the Council.

ARTICLE 10. ETHICS

The Principles of Medical Ethics of the American Medical Association and its subsequent amendments shall govern the conduct of the members of the Society in relation to each other and to the public.

ARTICLE 11. RULES OF ORDER

In the absence of any provision in the Bylaws to the contrary, all general meetings of the Society and all meetings of the House of Delegates, Council, and committees shall be governed by the parliamentary rules proposed by the Speaker of the House of Delegates and approved by the House of Delegates.

ARTICLE 12. AMENDMENTS

This Constitution and Bylaws may be amended in any general meeting of the Society by a majority vote of the members present and voting, provided the proposed amendment has been presented by the House of Delegates and has received its approval by a two-thirds vote of the Delegates present and voting.

ARTICLE 13. REPEAL OF PREVIOUS MOTIONS

On adoption of this Constitution and Bylaws, all previous Constitutions and Bylaws and motions of record, rules, and regulations in conflict with this Constitution and Bylaws are hereby repealed, provided that all officers, delegates, and elected committee members now in office shall continue their terms until their successors are duly elected as provided in the Bylaws.

BYLAWS

SECTION 1. MEMBERSHIP

1.1 *Categories.* Categories of membership are: (1) Active Constituent; (2) Active Direct; (3) Associate; (4) Affiliate; and (5) Honorary.

1.11 *Active Constituent.* Active Constituent members are members of constituent societies who are entitled to exercise the rights of membership in their constituent societies, including the right to vote and hold office, as determined by their respective constituent societies, and who fulfill one of the following requirements: (1) possess the degree of Doctor of Medicine, Doctor of Osteopathy, or their equivalents; and (2) possess an unrestricted license to practice medicine and surgery in Rhode Island.

A person eligible for Active Constituent membership in the Rhode Island Medical Society becomes a member of the Society upon certification by the secretary of the constituent society to the Executive Director of the Rhode Island Medical Society, provided there is no disapproval by the Council.

1.12 *Active Direct.* Active Direct members are those members who do not belong to a constituent society as defined in Section 1.1, but who fulfill one of the following requirements: (1) possess the degree of Doctor of Medicine, Doctor of Osteopathy, or their equivalents; (2) possess an unrestricted license to practice medicine; (3) are medical students in a school approved by the Accreditation Council on Medical Education; or (4) are residents serving in a training program approved by the Accreditation Council on Graduate Medical Education.

1.12(1) *Admission.* Active Direct members are admitted to membership upon application to the Executive Director, provided there is no disapproval by the Council.

Rights and Privileges. Active Constituent and Active Direct members are entitled to receive the *Rhode Island Medical Journal* and such other publications as the Council may authorize.

Dues and Assessments. Active Constituent and Active Direct members are liable for such dues and assessments as determined by the House of Delegates. Member spouses of Active Constituent and Active Direct members shall be liable for half the amount of all dues and assessments.

Exemptions. Upon written request, Active Constituent and Active Direct members may be exempt from dues and assessments on January 1 following their seventieth birthday regardless of practice status. Members younger than age 70 may be exempt from dues and assessments upon written request if they have retired from active practice.

Delinquency. Members are delinquent if their dues and assessments are not received by the Rhode Island Medical Society by May 1 of the current dues year or by such other date as the Council may specifically determine. Delinquent members shall forfeit their membership in the Society if delinquent dues and assessments are not received by the Society within 30 days after notice of delinquency has been mailed to the member's last known address by the Executive Director.

1.13 *Associate Members.* Associate membership is limited to those physicians who hold the degree of Doctor of Medicine, Bachelor of Medicine, or Doctor of Osteopathy who are members of a constituent society but are ineligible for Active Constituent or Active Direct membership in the Rhode Island Medical Society. Associate members are admitted to membership upon certification by the secretary of the appropriate constituent society to the Executive Director, provided there is no disapproval by the Council. Such members may attend the annual meeting of the Society, but may not vote or hold office. Associate members are subject to dues as determined by the House of Delegates.

1.14 *Affiliate Members.* Persons who belong to one of the following classes may become Affiliate members: (1) physicians who are members of national medical societies of foreign countries; (2) American physicians located in foreign countries or in possessions of the United States who are engaged in medical, missionary, educational, or philanthropic endeavors; (3) dentists who hold the degree of DMD or DDS who are members of the American Dental Association and their state and local dental societies; (4) pharmacists who are active members of the American Pharmaceutical Association; (5) teachers of medicine or the sciences related to medicine who are citizens of the United States, but who are ineligible for Active or Associate membership; (6) individuals engaged in scientific endeavors related to medicine and others who have attained distinction in their fields of endeavors, but who are not eligible for other categories of membership; and (7) Physician's Assistants (PAs) who have met the requirements of the Rhode Island Board of Registration for Physician's Assistants, are employed within the jurisdiction of the Society, and are supervised by and responsible to a physician who is an Active member of the Society.

Affiliate members are admitted by a majority vote of the Council following nomination by the Executive Director. Such members may attend the annual meeting of the Society, but may not vote or hold office. Affiliate members are subject to dues as determined by the House of Delegates.

1.15 *Honorary Members.* Honorary membership is extended to physicians of foreign countries, other states, or territories who have achieved preeminence in the profession of medicine, and other outstanding individuals in the health care field. Members in good standing who graduated from medical school more than 50 years ago and who have belonged to the Society for at least ten years may automatically become honorary members when recommended by their respective constituent societies. Honorary members are elected by the House of Delegates upon nomination by the Council. Such members may attend the annual meeting of the Society, but may not vote or hold office. Honorary members are not subject to dues or assessments.

1.2 *Maintenance of Membership.* A member may hold only one type of membership in the Rhode Island Medical Society at any one time. A member may retain membership only as long as he or she complies with the provisions of the Constitution and Bylaws of the Rhode Island Medical Society and the Principles of Medical Ethics of the American Medical Association.

1.3 *Transfer of Membership.* Active Constituent, Active Direct, or Associate members who move to another jurisdiction

or establish a medical practice in another jurisdiction may continue membership in the Rhode Island Medical Society without interruption by applying within one year for membership in the constituent society in the jurisdiction to which they have moved. Unless membership in the constituent society has been granted within two years after application, the Executive Director shall remove their name from the roster of members of the Rhode Island Medical Society.

1.4 *Termination of Membership.* The Executive Director, upon being officially informed that an Active or Associate member is not in good standing in a constituent society, shall remove the member's name from the roster of members.

1.5 *Discrimination.* Membership in any category of the Rhode Island Medical Society, or in any of its constituent societies, shall not be denied or abridged on account of color, creed, race, religion, ethnic origin, national origin, or sex.

1.6 *Discipline.*

1.6(1) *Active Constituent Members.* After due notice and hearing, the Council may censure, suspend, or expel any member for a violation of the Constitution and Bylaws or the Principles of Medical Ethics. Notice of intention to file an appeal must be filed with the Council within 30 days of the decision. The appeal must be filed within 60 days of the notice of intent to file an appeal. The Council, for good and sufficient cause, may grant an additional 30 days for filing the appeal.

1.6(2) *All Other Members.* The Council, after due notice and hearing, may censure, suspend, or expel any Active Direct, Associate, Affiliate, or Honorary member for a violation of the Constitution and Bylaws or the Principles of Medical Ethics who shall have the rights of appeal provided in Section 1.6(1).

SECTION 2. CONSTITUENT SOCIETIES

2.1 *Charters.* The constituent societies of this Society consist of those county or district medical societies which hold charters from this Society that are in full force and effect. All charters issued by this Society continue in full force and effect until revoked or suspended. The Council, with the approval of the House of Delegates, may charter, as a constituent society, a medical society which is representative of the medical profession of a county or district as circumstances may dictate. The House of Delegates shall have authority to revoke the charter of any constituent society whose actions violate the letter or spirit of the Constitution and Bylaws.

2.2 *Qualifications of Members.* Subject to the provisions of Section 2.3, each constituent society is the sole judge of the qualifications of its members and the acceptance of applicants is wholly at the pleasure of the constituent society. A constituent society may create classes or types of membership in addition to the types of membership of this Society, but only members of the constituent society with the membership qualifications required by these Bylaws may be members of this Society.

2.3 *Limitations.* Constituent societies are subject to the following limitations: (1) The Constitution and Bylaws of this Society and all subsequent amendments are the supreme law of the constituent society. If the Constitution and Bylaws of this Society contradict the bylaws of a constituent society, the latter are void; (2) A constituent society may admit to Active membership only those members who meet the minimum requirements stated in Article 1, and reside or practice in the territorial jurisdiction of the Society, except as the rules and regulations of this Society may otherwise provide; and (3) A member against whom disciplinary action has been voted by a constituent society shall have the right to appeal to the Council of this Society and to the Judicial Council of the American Medical Association under such rules as those two bodies may adopt. However, the disciplinary action voted by the constituent society shall remain in effect while any appeals are pending.

2.4 *Delegates and Councilors.* Each constituent society is entitled to elect one Delegate to the House of Delegates of this Society for each 50 active members, or major fraction thereof, of the constituent society. Regardless of the total number of active members, each constituent society is entitled to elect at least two Delegates, one of whom may be the president of the constituent society. Only Active members of this Society are eligible for election as Delegates or Alternates. The Delegates shall be selected by the constituent societies at their respective annual meetings, for one-year terms, which run from the meeting at which they were elected to the next annual meeting of the constituent society.

Each constituent society is entitled to elect one Councilor who shall be an Active member of the Society, and who shall serve a one-year term beginning at the close of the annual meeting at which he or she is elected.

2.5 *Vacancies.* If a Delegate or Councilor elected by a constituent society dies, resigns, ceases to be a member in good standing of the Society, becomes disabled, or for any other reason cannot assume the duties of his or her office, or will be absent from a meeting of the House of Delegates of this Society, the president of the constituent society may appoint another member to serve in his or her place during the balance of the term or during the disability or absence, as circumstances may permit. As soon as possible after the appointment, the president of the constituent society shall notify the Secretary of the Society of this action.

2.6 *Secretaries' Duties.* The secretary of each constituent society shall keep a roster of its members, grouping the members according to the type of membership held. With respect to each member, the roster shall contain the full name, address, date of birth, professional college and date of graduation, the date the member was licensed to practice in this state, and such other information as the Secretary of this Society may require. In keeping such records, the secretary shall note any change in the membership roster as the result of death or removal and shall so notify the Secretary of the Society. The secretary of the constituent society shall promptly notify the Secretary of the Society of losses of membership, giving the causes of individual cases.

2.7 *Membership and Place of Residence.* Any doctor of medicine residing near a county or district line may be elected to membership in that constituent society whose meetings will be most convenient for him or her to attend, if the action is acceptable to the constituent society where the physician resides.

Any doctor of medicine, who has his or her major office or professional practice in one county or district and resides in another county or district, has the option of applying for membership in either constituent society if the action is acceptable to both constituent societies.

SECTION 3. OFFICERS

3.1 *Election and Terms of Officers.* The House of Delegates at its annual meeting shall elect the following officers to serve one-year terms: President, President-Elect, Secretary, Treasurer, and Speaker and Vice-Speaker of the House

of Delegates. At the annual meeting in even years, the House shall elect the Delegate and Alternate Delegate to the American Medical Association to serve two-year terms. The Delegate and Alternate Delegate may serve a maximum of three two-year terms in their respective offices and a total of 12 years as both Delegate and Alternate Delegate.

The Council shall authorize a Nominating Committee to include the President, two Councilors, and two Delegates who do not serve on the Council. The President shall appoint the Councilors and Delegates and shall serve as chairman of the Nominating Committee. A list of nominees approved by the Council shall be mailed to the House at least one week before the annual meeting. Other nominations may be made from the floor of the House by any voting member of the House. All elections shall be by ballot, and a majority of the votes cast shall be necessary to elect.

The officers elected by the House, except for the AMA Delegate and Alternate Delegate, shall assume office at the close of the annual meeting of the Society and shall serve until the next annual meeting. The AMA Delegate and Alternate Delegate shall assume office on January 1 following their election in accordance with the Constitution and Bylaws of the American Medical Association.

3.2 *Vacancies.* If the President dies, resigns, is removed, or becomes disqualified before the expiration of his or her term, the President-Elect shall succeed to the office of President, with all its prerogatives and duties. Vacancies created by the death, resignation, or removal of other officers shall be filled by appointment by the Council for the unexpired portion of the term, except in the case of vacancy in the office of President-Elect when the Council shall submit a nominee to the House of Delegates.

3.3 *Duties.* In addition to the rights and duties provided elsewhere in this Constitution and Bylaws or as custom or parliamentary usage may require, the officers shall have the rights and duties respectively assigned to them in the succeeding sections of this article.

3.3(1) *President.* The President shall be responsible for the following rights and duties: (1) to preside at all general meetings of the Society and of the Council; (2) to serve as a member of the House of Delegates, Council, and Executive Committee;* (3) to deliver an address at the annual meeting; (4) to act as the spokesman of the profession in the state, and when advisable or necessary to visit personally, or appoint a representative to visit, the various constituent societies and to assist the councilors in strengthening the constituent societies; (5) to appoint delegates to other medical societies to serve for a one-year term and an anniversary chairman to preside at the next annual dinner; (6) to appoint and discharge all committees not otherwise provided for; and (7) to serve as an ex officio member of all committees.

3.3(2) President-Elect. The President-Elect shall, through active aid to the President and membership on the Council, House of Delegates, and Executive Committee, obtain the greatest possible knowledge of the affairs and personnel of the Society, to enable him or her to fulfill effectively the office of President upon succession. The President-Elect shall officiate for the President during his or her absence or upon request.

* By action of the AMA House of Delegates in June 1983, the Presidents of State Medical Societies also shall serve as additional alternate delegates to the AMA House of Delegates.

3.3(3) *Secretary.* The Secretary shall be responsible for the following rights and duties: (1) to keep minutes of the proceedings of the general meetings of the Society, the meetings of the Council, and meetings of the House of Delegates; (2) to be the custodian of the Society's seal; (3) to notify members of meetings, officers of their elections, committee members of their appointments and duties, and to send all notices required by this Constitution and Bylaws, by order of the House of Delegates or the Council, or by law; (4) to provide for the registration of members and delegates at general meetings of the Society and of the House of Delegates and to keep a record of such registration; (5) to keep a register of all constituent societies, their respective officers, and all members of the Society, and to transmit a copy of this list to the American Medical Association with the names of new members and the names of those dropped from the membership roster; (6) to keep a register of all licensed physicians in the state who are members of the Society, by county, noting the status of each in relation to the appropriate constituent society; (7) to be the custodian of all record books and papers of the Society, except those which properly belong to the Treasurer; (8) to report annually to the House of Delegates; (9) to prepare and issue all programs as may be directed by the Annual Meeting and Awards Committee; (10) to aid the Council on the organization and improvement of the constituent societies and in the extension of power and usefulness of this Society; (11) to perform such other duties as may be required by the Council or the House of Delegates; (12) to serve as an ex officio member of all standing committees; and (13) to serve as a member of the House of Delegates, Council, and Executive Committee.

3.3(4) *Treasurer.* The Treasurer shall have the following rights and duties: (1) to serve as a member of the House of Delegates, Council, and Executive Committee; (2) to maintain the records of the dues of each member and to demand and receive all funds due the Society, including bequests and donations; to deposit these funds in a depository approved by the Council; and to keep an accurate record of all funds of the Society; (3) to present a budget of necessary expenses of the Society for the following year to the Council, for its approval, at the Council meeting preceding the House of Delegates meeting in September, and to pay all bills within the scope of the approved budget; (4) to pay bills not within the scope of the approved budget only on order of the Council; (5) to invest the funds of the Society under the supervision of the Council; (6) after receiving the recommendation of the Council, to sell, mortgage, or lease any property belonging to the Society, and to execute the necessary legal documents thereto; (7) when directed by the House of Delegates, to sue in the name of the Society and to prosecute such suits to final judgment and execution; (8) to subject the accounts of the Society to annual examination by the auditors; (9) to render an account of his or her work and of the state of the funds of the Society annually, and to present such other written reports as the House of Delegates or Council may require; (10) to employ such assistants as may be authorized by the Council; and (11) to give bond in such sum as may be fixed by the Council, the premium on such bond to be paid by the Society.

3.3(5) *Speaker of the House of Delegates.* The Speaker shall serve as a member of the Executive Committee and the Council. The Speaker shall preside at the meetings of the House of Delegates and shall perform such duties as

custom and parliamentary usage may require. The Speaker may address the House of Delegates at the opening of each meeting, limiting comments to matters of conduct and procedure in the House. The Speaker is entitled to vote when the vote is by ballot or roll call. In all other cases, the Speaker shall have the right to vote only in the case of a tie.

3.3(6) *Vice-Speaker of the House of Delegates.* The Vice-Speaker shall serve as a member of the Council. The Vice-Speaker of the House of Delegates shall officiate for the Speaker in the latter's absence or upon request. In case of death, resignation, or removal of the Speaker, the Vice-Speaker shall officiate during the unexpired term. The Vice-Speaker is entitled to vote when the vote is by ballot or by roll call.

3.3(7) *AMA Delegate.* The Delegate shall represent the Society at the American Medical Association in conformity with the applicable provisions of the Constitution and By-laws of the American Medical Association.

3.3(8) *AMA Alternate Delegate.* The Alternate Delegate to the American Medical Association shall function for the Delegate in the latter's absence or upon request. In case of death, resignation, or removal of the Delegate, the Alternate Delegate shall function as the Delegate for the remainder of the unexpired term.

3.4 *Reports of officers.* The Secretary, for the Council, and the chairmen of committees, shall prepare reports, preferably in writing, for the consideration of the House.

SECTION 4. HOUSE OF DELEGATES

4.1 *General Powers.* All legislative power of the Society is vested in and resides in the House of Delegates, which alone shall have authority to determine the policies of the Society. It shall: (1) elect all the officers; (2) elect such delegates to the American Medical Association to which the Society may be entitled; (3) elect the standing committee members; and (4) determine the annual dues and assessments.

4.2 *Composition.* The House of Delegates shall be composed of:

4.2(1) Delegates elected by the constituent societies. Each constituent society is entitled to elect one Delegate for each 50 Active members in good standing, or major fraction thereof, exclusive of resident physicians in good standing, with the added provision that each constituent society shall be entitled to elect at least two Delegates, one of whom may be the president of the constituent society.

4.2(2) One Delegate from each officially recognized specialty society. An officially recognized specialty society must have at least 12 active members of the Society, and at least 75 per cent of its membership must be active members of the Society, must have its request approved by the Council and the House of Delegates, and its Delegate must be an active member of the Rhode Island Medical Society.*

4.2(3) One Delegate from each officially recognized hospital medical staff association. An officially recognized medical staff association must have at least 75 per cent of its active members as active members of the Society, must have its request for representation in the House of Delegates approved by the Council and the House of Delegates, and its Delegate must be an active member of the Rhode Island Medical Society.†

4.2(4) The President, President-Elect, Secretary, Treasurer, Immediate Past President, Speaker, Vice-Speaker, and AMA Delegate and Alternate Delegate.

4.2(5) Without the power to vote unless elected as a Delegate from a constituent society, an officially recognized specialty society, or an officially recognized hospital medical staff association, the Editor-in-Chief of the *Rhode Island Medical Journal,* the Director of the Rhode Island Department of Health, and the presidents of the constituent societies.

At his or her discretion, the President may appoint a parliamentarian who shall serve without a vote unless he or she is a Delegate from a constituent society, an officially recognized specialty society, an officially recognized hospital medical staff association, or serves as an officer of the Society.

4.3 *Tenure of Office.* A Delegate to the House of Delegates of the Rhode Island Medical Society may serve a maximum of six successive years, and shall be ineligible for re-election as a Delegate for at least one year after such a six-year tenure.

4.4 *Time of Meeting.* The House of Delegates shall meet in January and September, and also annually at such place and time as the President may determine. The House may be called into special session at any time during the year by the President at his or her discretion or on the written petition of 10 Delegates or 25 members.

4.5 *Reporting of Proceedings.* When the House of Delegates meets, the Secretary shall publish a summary of the proceedings as soon as possible in the Society's official publication.

4.6 *Conduct of Business.* The House of Delegates shall be presided over by the Speaker, and in the absence of the Speaker by the Vice Speaker, and in the absence of the Vice-Speaker by the President, and in the absence of the President by any Delegate agreeable to the House of Delegates. Twenty delegates shall constitute a quorum for the transaction of business. The Secretary shall record the proceedings.

The House of Delegates may, by a two-thirds vote of its own members, submit any question before it to the membership of this Society for a general referendum by ballot sent by mail and it shall be bound by the result.

4.7 *Duties and Powers*

4.7(1) *Special Committees.* The House of Delegates may appoint committees composed of any members of the Society for special purposes or it may provide for such committees and authorize the appointment of members by the President. Such committees shall report to

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* Specialty societies represented in the House of Delegates as of May 29, 1985 which do not satisfy the membership requirements shall be granted representation until June 1, 1988, after which they shall lose the right of representation in the House of Delegates until such time as they meet the membership requirements.

† Hospital medical staff associations which do not satisfy the membership requirements shall be granted representation until June 1, 1988, after which they shall lose the right to representation in the House of Delegates until such time as they meet the membership requirements.

the House of Delegates. Members of such committees may participate in discussion and debate on their reports, but shall not have the right to vote unless they are Delegates.

4.7(2) *Fixing of Annual Dues.* The House of Delegates at its September meeting shall determine dues for the following fiscal year.

SECTION 5. THE COUNCIL

5.1 *General Powers.* The Council shall implement the mandates and policies of this Society as determined by the House of Delegates or by referendum or initiative measures. Subject only to the provisions of these Bylaws, actions of the House of Delegates, and measures initiated at general meetings of the Society, the Council has full and complete power and authority to perform all acts and to transact all business for the Society and to manage and conduct all of the property, affairs, work, and activities of the Society.

5.2 *Composition.* The Council shall consist of the Councilors elected by the constituent societies; the presidents of the constituent societies; the three most recent living past presidents of the Society, if active members; the President, President-Elect, Secretary, Treasurer, Delegate and Alternate Delegate to the American Medical Association, the Speaker and Vice-Speaker of the House of Delegates, and the President of the Staff Physicians Association of Rhode Island (SPARI), if an active member.

5.3 *Election and Tenure of Councilors.* Each constituent society shall be entitled to elect one Councilor who shall assume office at the end of the annual meeting of the constituent society and serve until its next annual meeting. A councilor may serve a maximum of six successive years and shall be ineligible for re-election as a councilor for at least one year after each six-year tenure.

5.4 *Meetings.* The Council shall meet bi-monthly at such time and place as the President may determine. The President may call a special meeting of the Council on his or her own motion and must call a special meeting on the written request of three members of the Council. Ten members shall constitute a quorum. The President shall preside at the meetings of the Council, and in his or her absence, the President-Elect. The Secretary shall keep a record of its proceedings.

5.5 *Duties and Powers.*

5.5(1) *Ethics.* In addition to the duties and powers conferred on the Council elsewhere in the Constitution and Bylaws, the Council shall act as the arbiter of the Society on ethical issues and questions involving the rights and standing of members, whether in relation to other members, to the constituent societies, or to this Society. When its jurisdiction is invoked as provided in Section 1.6, it shall review instances in which disciplinary orders or measures have been adopted by a constituent society against a member.

5.5(2) *Appeals and Disciplinary Proceedings.* A member of a constituent society who is censured, suspended, expelled, or otherwise disciplined by his or her constituent society, may file a notice of appeal to the Council within 30 days of such disciplinary order for a determination of applicable questions of law and procedure, but not of fact. Appeals shall be in writing and must be filed with the Secretary within 60 days of the notice of appeal. On the filing of an appeal, the Secretary shall notify other members of the Council. Appeals shall be heard by the Council only after reasonable notice in writing of not less than ten days of the time and place of the hearing on the appeal has been given to the appellant member and the president and secretary of the constituent society.

In every case of appeal, the Council, before any hearing of the appeal, shall exert all proper efforts at conciliation and compromise. The decision of the Council shall be final and bind the appellant member and the constituent society, unless the matter is carried on a timely basis to the Judicial Council of the American Medical Association.

5.5(3) *Compensation of Officers and Employees.* The Council shall fix the compensation of the officers, representatives, and employees of the Society.

5.5(4) *Executive Director.* The Council may employ an Executive Director of the Society after authorization by the House of Delegates.

5.6 *Executive Committee of the Council.* The Executive Committee shall transact the business of the Society during intervals between Council meetings and function in an advisory capacity to the President in his or her role as a public spokesman for the Society. The Executive Committee shall meet bi-monthly in the intervals between Council meetings, and at the discretion of the President. The Executive Committee of the Council shall consist of the President, President-Elect, Secretary, Treasurer, Immediate Past President, and Speaker of the House of Delegates. All Executive Committee actions shall be reported to the Council at its next meeting.

5.7 *Report to the House of Delegates.* The Council shall report at each session of the House of Delegates on the state of the Society and the work and proceedings of the Council during the interval since the last session of the House.

SECTION 6. MEETINGS

6.1 *Annual Meeting.* The Society shall hold an annual meeting at such place and time as the President may determine. The Secretary shall give each member at least seven days' notice of the annual meeting.

6.2 *General Meetings.* During the annual meeting, there shall be at least one general meeting open to all registered members. The general meeting may recommend to the House of Delegates the appointment of committees or commissions for scientific investigations of special interest and importance to the profession and the public. The general meeting, by a two-thirds vote of the members present, may order a general referendum on any question pending before the House of Delegates. When so ordered, the House of Delegates shall submit such question to the members of the Society by mail ballot. A majority of such votes shall determine the question and be binding on the House of Delegates. The general meeting may receive and vote on resolutions introduced at any meeting of the House of Delegates, but the resolutions shall not be binding on the Society until approved by the House of Delegates.

6.3 *Special Meetings.* A special meeting of the Society may be called by the President at his or her discretion and must be called on the written petition of 25 members.

6.4 *Right of Members to Participate.* All members of the Society may attend, and except as otherwise limited, may participate in the annual meeting held by the Society, subject only to such reasonable parliamentary rules as may be adopted. Members may also attend meetings of the House of Delegates, except when the House of Delegates is in executive session. Except with the consent of the House of

Delegates, however, no member who is not a Delegate may have the privilege of the floor.

6.5 *Registration Required.* Before a member can attend and participate in proceedings or activities of the annual meeting, he or she must register under such procedures as the Secretary may determine.

6.6 *Guests.* The privilege of attending the annual meeting may be extended to guests under such conditions as the Secretary may determine.

SECTION 7. FINANCE

7.1 *Fiscal Year.* The fiscal year of this Society is from January 1 to December 31.

7.2 *Supervision.* Supervision of funds, investments, and expenditures of the Society is vested in the Council. The Council shall receive the audited accounts of the Treasurer and other agents of the Society and present a statement of those accounts in its annual report to the House of Delegates. It shall report on all resolutions appropriating money and shall submit such report to the House of Delegates for authorization or approval. At the meeting of the House of Delegates in September, the Council shall submit a budget for the expected income and expenses of the necessary appropriations and impose such conditions on the expenditure of the funds so appropriated as it sees fit, provided, in the case of an emergency, the Council may authorize the expenditures of funds for items not included in the budget that year.

SECTION 8. STANDING COMMITTEES AND BOARDS OF TRUSTEES

8.1 *Names of Standing Committees and Election of Committee Members.* The standing committees of the Society, of which the President and Secretary shall be ex officio members. shall include in alphabetical order: Annual Meeting and Awards, Impaired Physician, Liaison, Library, Mediation, Medical Economics, Occupational Health, Peer Review Committee on Physician Competency, Public Laws, Publications, Quality Assessment, Standards and Credentials, Trustees of the Caleb Fiske Fund, and Trustees of Special Funds. Except as noted below, committee chairmen and members shall be elected by the House of Delegates at its annual meeting for one-year terms. They shall assume office at the close of the annual meeting of the Society and shall serve until the next annual meeting. The nomination process for committee chairmen and members shall be the same as described in Section 3.1.

8.1(1) *Annual Meeting and Awards.* The Annual Meeting and Awards Committee shall consist of nine members elected by the House of Delegates. The committee shall determine the character and scope of the scientific proceedings of the Society for each annual meeting, subject to instruction of the House of Delegates. It shall be the duty of the committee to provide a suitable place and to make all necessary arrangements for the annual meeting of the Society. The committee shall prepare and issue at least seven days before each meeting a program announcing the order in which papers, discussions, and other business shall be transacted. The committee also shall be responsible for selecting recipients of the Chapin Oration Award and other awards and presentations made at the annual meeting.

8.1(2) *Impaired Physician.* The chairman of the Committee on the Impaired Physician shall be elected by the House of Delegates. The chairman, with the advice and consent of the President, shall appoint the committee members. The committee shall be charged with providing aid and assistance to physicians whose professional judgments and capacities are impaired by their difficulties with chemical dependencies or other illnesses.

8.1(3) *Liaison Committee.* The Liaison Committee shall consist of at least five members elected by the House of Delegates. The committee shall be responsible for monitoring the professional activities of health maintenance organizations relating to the delivery of medical care, including protocols, standards of care, and related matters in order to assist them in maintaining quality of care. The committee shall report back to the Council on achievements and problems in this area.

8.1(4) *Library.* The Library Committee shall consist of nine members elected by the House of Delegates. In consultation with the Librarian, the Committee shall be responsible for establishing the rules and operating procedures concerning the use of the Library. In addition to customary functions, the Library shall also be a repository and hold the archives concerning medical history and physicians of Rhode Island. The Executive Director, after consultation with the Library Committee, shall appoint a qualified Librarian. The Librarian shall acquire and catalogue additions to the Library, provide reference services, and perform such other duties as may be assigned by the Executive Director.

8.1(5) *Mediation.* The Committee on Mediation shall consist of 10 members. The committee shall elect a chairman and a vice-chairman to serve for annual terms. Annually, the President of the Society shall appoint one member for a term of 10 years to replace the member whose term expires. The President may appoint himself or herself, or reappoint a member whose term expires, but all appointees must be members in good standing of the Rhode Island Medical Society. If a vacancy occurs on the committee, the President, with the advice and consent of the Council, shall appoint a member to complete the unexpired term.

The commitee shall review all cases of threatened or instituted action for malpractice against any member of the Society, and shall also investigate all complaints concerning the professional conduct of members referred to it.

The committee shall have authority to require the attendance of any member to answer allegations of unprofessional conduct, upon at least seven days written notice to the member. Failure of the member to appear before the committee without justifiable cause shall be reported to the Council for disciplinary action. The committee, after investigation, shall have the authority to refer charges of unethical or unprofessional conduct against a member to the Council.

8.1(6) *Medical Economics.* The Committee on Medical Economics shall consist of nine members elected by the House of Delegates. The committee shall be charged with investigating issues related to the costs of delivery of medical care and recommend ways of containing medical care costs to the public, insurance companies, governmental agencies, and other organizations. It shall be concerned with health insurance programs and medical service plans. It shall initiate or make recommendations to the Council on group insurance programs and services for the benefit of the membership.

8.1(7) *Occupational Health.* The Committee on Occupational Health shall consist of nine members elected by the House of Delegates. The Committee on Occupational Health shall keep itself informed concerning: (1) actual conditions and practices in industry affecting or relevant to the health and well-being of industrial workers; (2) the medical care rendered as a result of industrial accidents or occupational diseases; and (3) legislation pertinent to the field of occupational health. The committee shall also study, determine, and advocate such measures as in its judgment will improve the welfare of the industrial worker. The committee shall cooperate with other agencies having a legitimate interest in the health of industrial workers. It shall coordinate its activities, so far as possible, with the activities of the American Medical Association.

8.1(8) *Peer Review Committee on Physician Competency.* The Peer Review Committee on Physician Competency shall be composed of at least 12 members elected by the House of Delegates. Committee members should reflect the geographic distribution and specialty representation of the state. The committee shall consider allegations of questionable physician competence from any person or organization and, if appropriate, shall propose remedial actions to restore the physician's practice to professionally accepted standards.

8.1(9) *Public Laws.* The Committee on Public Laws shall include a Chairman and five members elected by the House of Delegates and the presidents of the seven constituent societies. The committee shall review all legislation in the state legislature of professional interest to the Society in light of the Society's policies and recommend appropriate positions to the President. In the absence of a stated policy, the committee shall recommend a policy position to the Council for adoption.

8.1(10) *Publications.* The Committee on Publications shall consist of nine members elected by the House of Delegates. The committee shall arrange for the publication and distribution and have charge of the Society's official journal. Expenses of the committee must be authorized by the Council and subsequently reported to the House of Delegates. All receipts shall accrue to the Treasurer.

8.1(11) *Quality Assessment Committee.* The Quality Assessment Committee shall consist of at least five members elected by the House of Delegates. The committee shall be responsible for evaluating the impact of decision by third-party payers and other health care delivery systems on the quality of medical care.

8.1(12) *Standards and Credentials.* The Committee on Standards and Credentials shall consist of nine members elected by the House of Delegates. The committee shall determine standards for course content to satisfy the continuing medical education requirements for registration of medical licenses in Rhode Island. In special cases, the committee shall evaluate an individual physician's course of study to determine if the requirements have been met.

8.1(13) *Caleb Fiske Fund.* The President, President-Elect, and Secretary shall be the Trustees of the Caleb Fiske Fund.

8.1(14) *Other Special Funds.* The President, Secretary, and Treasurer shall be the Trustees of such special funds as have been created and may be created hereafter, provided other trustees are not designated by the creators of the fund or appointed by the House of Delegates.

8.2 *Vacancies.* If an elected or appointed committee member dies, resigns, is removed, or fails to serve, the Council shall appoint a member of the Society to serve for the unexpired portion of the term.

8.3 *Required Reports.* Each committee shall report annually to the House of Delegates, preferably in writing, concerning its activities. The Trustees of the Caleb Fiske Fund and Trustees of Special Funds shall report to the Council.

SECTION 9. DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

9.1 *Selection and Terms.* The House of Delegates at its annual meeting in the even year shall elect a Delegate and Alternate Delegate to the House of Delegates of the American Medical Association, in conformity with the applicable provisions of the Constitution and Bylaws of the American Medical Association.

9.2 *Assumption of Office.* The Delegate and Alternate Delegate shall assume office on January 1 of the year succeeding their election, for two-year terms, and shall serve until their successors are elected and assume office.

9.3 *Vacancies.* If before the termination of his or her term, the delegate dies, resigns, ceases to be a member in good standing of the Society, becomes disabled, or for any other reason cannot assume or continue the duties of office, or will be absent from a session or meeting of the House of Delegates of the American Medical Association, the alternate delegate shall assume the rights and duties of office for the time being or for the remainder of the term as appropriate, in the opinion of the Council.

9.4 *Tenure.* The Delegate and Alternate Delegate to the American Medical Association may serve a maximum of three two-year terms in their respective offices and a total of 12 years as both Delegate and Alternate Delegate.

Rhode Island Medical Society
106 Francis Street
Providence, Rhode Island 02903
401/331-3207

PRESIDENTIAL ADDRESS

The Present Condition of Medical Practice in Rhode Island and the Outlook for the Future

First I should like to thank the Rhode Island Medical Society for the opportunity to give up most of my spare time for a year. There is no cause more worthy than our efforts to protect our patients. The Society does not function through the efforts of doctors alone. The members set policies and goals, but expert execution is the responsibility of staff. Our staff gives beyond the call of duty.

Basic to the function of the Society are the efforts of our staff: Libia Rattigan, Donna Cicerone, Edwina Rego, Carole Powers, and Alexandra Berl. The library is a model of efficiency and a pleasure to use because of our always pleasant librarian, Marcia Sessions. Wendy Smith has brought the *Journal* to a new level of sophistication and even financial independence. I know of no one in any organization who is as dedicated and has such varied talents and interests as Newell Warde. Our legislative effort and success is his responsibility among many others, and I can tell you that without his dedication our presence in the State House would be markedly diminished. Many of our other programs would be of lesser quality. The level of professionalism with which our society functions in all areas is directly attributable to the unique talents of Doctor Norman Baxter. Although he may not agree, I think that being a college president is good training for running a medical society. I am not sure which is easier to cope with: youthful and energetic students or aging and individualistic doctors. My association with Doctor Baxter has been a high point of the year. Special gratitude is due to my wife and children for their loving support and willingness to do without me for much of this year.

Physicians in Rhode Island have taken a beating in the public eye during the past year because of the misadventures of one notorious offender.



Herbert Rakatansky, MD

The trial lawyers carp that there would be no malpractice crisis if there were no "bad doctors." The public perceives that there are a few "bad apples" and that, if once and for all they were weeded out, the profession would be pure and there would be a uniform quality of treatment. The lawyers are wrong and the public is wrong. What is needed is a system of constant review to ensure that the practice of medicine meets minimum standards.

The few doctors who practice below minimal acceptable standards fall into three categories:

First, impaired physicians are those whose practice is inadequate because of illness. Generally, the illness is behavioral in nature, such as addiction (alcohol, drugs, or both), depression, and other mental illnesses. The Impaired Physicians Committee is a recognized resource for treatment. Eighty-five per cent of addicted doctors who follow its recommendations successfully return to a productive practice and remain well

Delivered at the 175th Annual Meeting of the Rhode Island Medical Society, May 30, 1986.

for five years. Those few who will not or cannot cooperate are reported to the state disciplinary board.

Second, incompetent physicians are those who unknowingly practice below the minimal acceptable standard. They have failed to stay current because of lack of motivation, time, or other reasons. The Society has established a committee on physician competence which will evaluate such cases and recommend remedial education or other courses of action. We are working actively with Health Care Review, Inc of Rhode Island, the professional review organization, to assist physicians discovered by their review mechanism before the matter becomes serious enough for the federal government to intervene. In case of refusal to cooperate on the part of the physician, the matter is referred to the state disciplinary board. The first report of this committee was presented to the House of Delegates this afternoon.

Third, physicians knowingly practicing below minimal standards are referred to the Mediation Committee of the Society. This committee considers questions of ethics. Often, minor ethical matters can be resolved promptly by the use of peer pressure. If the motivation appears to be criminal, the physician is referred to the appropriate state authority.

Many problems are resolved by these committees to the satisfaction of all. The physician is restored to health, the level of practice is elevated, and the public is protected. All this is done without significant cost to society and in a timely manner.

I should like to consider the malpractice problem further. Under the present system, the trial attorneys represent themselves as agents of social justice, protecting the public. While such a concept may be appropriate when a large corporation is allegedly victimizing a poor and lonely individual consumer, this model does not apply to the doctor-patient relationship. In the medical model there are two objectives: first, to compensate the patient promptly and fairly for injury due to negligence, and second, to maintain the level of medical practice at an acceptable level.

Under the present system neither of these objectives is achieved. Not only does the present tort liability system not protect the public individually and collectively, but it threatens to limit the quality and availability of medical care because of skyrocketing costs. The alternatives which are being proposed would put controls on the system such as we put pharmacologic and physical controls on a violent patient. The cornerstone of this effort includes a cap on awards for pain and suffering and on attorneys' contingency fees. I believe that, while such efforts may control the costs and we do support these measures, they will not accomplish the objectives of paying the patient fairly and promptly and insuring a system of quality medical care.

The solution, I believe, must be a total revision of the system rather than tinkering with the controls. The payment of patients for negligent injury should be separate and apart from the disciplinary function. If doctors were not afraid of incriminating themselves or their friends, they would be likely to assist patients in recovering fair compensation. Such a concept could conceivably expand to include payment for disasterous and unexpected results not attributable to negligence. This kind of a "no-fault" system would provide infinitely more justice to the patient than the present legal morass and at a lower cost.

A strong peer review function provided by the Rhode Island Medical Society and backed up by a powerful and aggressive state disciplinary board provides the other arm to this system. Not all "incompetent" doctors produce grievous patient injury. Under the present system only those doctors who have injured a patient are brought in to the disciplinary arena. In each case the doctor must hire a lawyer to protect his interests and in the adversarial situation is forced to deny any negligence or lack of competence or skills.

How much better for everyone it would be if the patient were paid promptly. How much better it would be if the "below standard" doctor could be identified and helped or guided out of practice before patients were injured.

I believe that separation of discipline for physicians and compensation for patients represents the best hope for the continuation of high quality of medical care. The Society can and should be instrumental in designing and implementing such reforms.

A different threat, that of cost control, is threatening like a tidal wave to engulf us. Attempts to control costs have resulted from the fact that the total expenditure for medical care is perceived to be unacceptably high. Cost control has two basic origins. The government curtails various expenditures after considering the multiple functions it must provide to its citizens on a finite budget. The limitation on medical care is a conscious decision by the public to achieve some other socially desirable goals. As doctors, we may disagree, but as members of a democratic

society we can understand the process.

Third parties such as health maintenance organizations make a profit by limiting the amount of medical care provided to their subscribers. This is a qualitatively different situation from government intervention. Politicians are ultimately responsible to their constituents. Who protects the patient from the avarice of stockholders of a large and anonymous corporation whose arbitrary decisions are motivated by profit rather than social policies arrived at by democratic consensus? Sadly, the public will never be aware of the decrease in the quality of medical care unless someone tells them.

I maintain that organized medicine has an obligation to monitor the quality of care provided by these organizations and provide feedback to the public. No one else has the knowledge and training to do this. This year the Society has established a liaison committee to work with the HMOs in Rhode Island in the establishment of appropriate medical protocols and standards of care. While we cannot force an HMO to accept any standards, we can and will publicize inappropriate standards to our members and to the public. With adequate information the public can choose systems of medical care most appropriate for their needs and desires. Providing such information may be one of our most important functions.

As these new systems deliver less health care one or both of two results will follow. First, high quality health care will be delivered to fewer persons, and some will go without. Second, a lesser degree of health care will be delivered to some, if not all, persons.

Who will receive the blame for the decreasing quality and quantity of health care? In the first instance, where fewer people receive care, the blame will rest with the system itself or perhaps with the government or large corporation. For this very reason the forces which require restriction of health care in order to save money will choose the second alternative. If diminished health care is distributed among the population at large, physicians will receive the blame. By putting the restriction on a personal level, the individual patient will perceive that his individual doctor is responsible.

We must not allow this to happen. We must put the blame where it belongs and not accept responsibility for decisions which we did not make. In each instance in which we cannot deliver what we think is the appropriate level of medical care, we should document our professional judgment in writing. Obviously, this should be on the medical record, but also should be presented in understandable terms to the patient so that he realizes the origin of the limitation of his care. The source of the limitation, be it a hospital, HMO, government agency, or other organization, should receive a copy. If we do this consistently, the public will realize the origin of the defects of the system. They may then choose to accept the system, or they may elect to change it. The physician does not have a choice. He must always recommend the best available care for his patient. If he abandons this standard, he abandons his position as an advocate for his patient.

In order to accomplish some of the goals outlined, I think it is important for the Rhode Island Medical Society to focus its efforts and energies. We cannot do everything. It is time to question whether our support of a monthly scientific journal and an extensive library is appropriate in this modern day when it may mean sacrificing other goals such as those I have mentioned.

We have been effective this year in presenting our message to the public and to the legislature. I think that there is greater awareness of the malpractice problem, and the impact of the physician is more favorable than it would have been if we had been represented in the press only by Doctor Felix M. Belasco, recently convicted of a federal charge of fraud. This momentum generated in the legislative arena and in the media must continue. Recognizing this, the Executive Committee has instructed the Executive Director to redefine the duties of the assistant executive director to include major responsibilities in the area of public relations and legislative liaison. It is absolutely essential that we have such expertise in-house.

Our breakfast and dinner meetings with the legislators were successful because of the good attendance by all of you. Personal and repeated contact with our legislators must continue throughout the year. The Society will continue to lead in this effort.

We have discussed some of the enemies of quality medical care. There are also some friends. Some Brown University Program in Medicine policies or actions may be in conflict with the views of some of our members, but I believe Brown is committed to high quality medical practice. The Society can and should be a means of liaison for cooperation of our common goal.

The Society has been in court twice this year. We filed a brief in a case in Westerly in which the confidentiality of peer review records was

threatened. That case was decided in our favor. Recently we sued the Director of Business Regulation to abolish the 16⅔ malpractice premium surcharge. A hearing is scheduled for June 17.

In order to achieve these goals, it is critical to maintain our membership at the highest possible level. Other organizations may develop in response to the changing times, but will not have the depth and resources or the effectiveness of the Rhode Island Medical Society and the American Medical Association. I realize that I am preaching to the choir here, but I urge each person to appoint himself a one person membership committee. If you know of a colleague who is not a member, take it upon yourself to approach him and encourage him to join. Personally, I do not like to ask for money, but I do not mind asking a doctor to contribute to his own welfare.

Recently I was performing one of my special procedures best left only vaguely described in this before dinner-hour on a patient named Joe. He was a recipient of public assistance, more popularly known as "welfare." With a big smile on his face, Joe described how he had seen me on television the previous evening. He told how he called his friends over to the TV set and proudly pointed out "his doctor." They responded that I could not be his doctor with the comment that "you can't afford a doctor like that." I hope that our medical system remains intact and that not only will Joe be able to afford "his" doctor, but that society will permit him to continue to receive the kind of care he needs.

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SPECIAL REPORT

Missing and Exploited Children

Missing children are defined as individuals under the age of 18 who are victims of abductions by noncustodial parents or by strangers, as well as runaways and those who are acutely vulnerable because of parental abandonment, parental homelessness, or other major catastrophes in the family. Runaways are categorized as voluntary runaways and "throwaways," with the latter including young people forced out of their homes by parents. Exploited children are defined as sexually victimized youngsters involved in any one or more of the following activities: child pornography, child prostitution, or child sex rings.

This paper presents background information on the nature and extent of the problem as well as national and legislative initiatives that address the issues of missing and exploited children. Outlined are health problems of this patient population, the role of the physician, prevention strategies, research and training issues, and activities of health organizations.

Background

Although the magnitude of the missing child problem is not well documented, experts estimate that as many as 1.5 million children and adolescents may be affected during any given year. About 1.1 million of these are believed to be runaways and homeless youth who are at significant risk for injury, illness, street crime, and violent death.[1] Estimates of the number of children abducted annually are far-ranging, but at least tens of thousands of children are involved.

It is not known how many children and adolescents are on the streets or living in extreme poverty because of parental homelessness, parental abandonment, or severe problems involving family disintegration. Of the children who are missing, some will return home, some will be found, some will never be reunited with their families, and some will die. Children who are abducted at a very young age may grow up without knowing who they really are, or forgetting many of their early life experiences and family relationships.

Many runaways have been neglected since early childhood, physically or sexually abused by parents and foster parents, pushed out of the home, or deprived of consistent support and discipline. Some experts estimate that as many as 50 per cent of the children served by some community runaway programs have been seriously abused by their families.[2] Available research suggests that various combinations of psychological characteristics of children, together with strained family relationships, are central factors associated with runaway behavior. The problem is compounded by school difficulties and deviant group behavior that results in adverse peer pressure.[3]

Although a significant number of runaways come from impoverished families, many are in flight from middle-class and upper-class homes. Once on their own, young people may live in abandoned buildings or on the street. They lack the skills or knowledge to find or hold a job. In this context, survival becomes the key issue for these youngsters, with drugs, prostitution, and child pornography emerging as staples of the street culture. Especially in urban centers, delinquent or criminal behaviors such as gang warfare, burglary and armed robbery, prevail. Escape from this environment is problematic for a great number of runaways, since reconciliation with the family and a return to the home is impossible.[2]

The child pornography industry alone is a highly sophisticated multimillion dollar enterprise involving thousands of children. Again, survival is the overriding concern for many youngsters who become involved in the trade. Law enforcement officials and behavior scientists point out that the victims must sell themselves to

This paper was adapted from a report of the American Medical Association Board of Trustees to the House of Delegates at the 1986 Annual Meeting, June 15-19, Chicago.

survive and, in doing so, mistakenly interpret seduction as affection. Children who pose in the nude may make an easy progression to prostitution and pornographic movies.

Although runaways constitute a large number of youngsters involved in commercial sexual exploitation, they are not the only resource for filmmakers or photographers. Filmmakers may use their own children or children in the neighborhood. Some children are sold by their parents to willing buyers, often to support a parent's alcohol or drug problem.[4]

On another level, alienation from school and longstanding academic and behavior problems have culminated in overwhelming special needs for runaways. For those who are homeless, assistance in making the transition into adulthood is needed. Basic survival skills and job training are crucial.[2]

Young people who are vulnerable to running away often signal this fact by behavior that may come to medical attention, or they may divulge their plight to a sympathetic medical professional in time to be stopped.

A clear majority of child abductions represent noncustodial parental kidnappings.[5] With the increase in the number of divorces, decisions regarding custody of children are being challenged outside courtrooms in the form of parental abductions. Sometimes the abductions can occur prior to a custody determination. Often the child is taken to a distant location — away from family and community supports. Chidren abducted by noncustodial parents experience many of the same problems as runaway children. These youngsters are vulnerable to physical and sexual abuse as well as neglect.[6] The plight of children abducted by strangers appears to be even more precarious. The FBI Academy's Behavioral Science Unit broadly categorizes these abductors as psychotics, pedophiles, profiteers, and serial killers.

Legislative Initiatives

In 1982, Congress passed legislation that requires the FBI to keep more detailed records on missing and unidentified persons. Two years later, another statute mandated the establishment of a national resource center on missing children and a national toll-free telephone line. Provisions of the 1984 law also called for (1) initiation of national incidence studies on a periodic basis; (2) technical assistance to law enforcement agencies, state and local governments, the criminal justice system, public and private nonprofit agencies, and individuals in the prevention, investigation, prosecution, and treatment of missing and exploited children; (3) effective coordination among all federally funded programs related to missing children; and (4) analysis, publication, and dissemination of an annual summary of research and demonstration projects.

The federal Runaway and Homeless Youth Act, enacted in 1974, called for the funding of centers to provide shelter for runaways and homeless youth, a national communications network, coordination among centers, and technical and training assistance. The purpose of this legislation was to provide grants to community-based agencies, located outside the law enforcement and juvenile justice systems, for the purpose of developing new or supporting existing programs that address the immediate needs of runaway youth. Program performance standards have been developed for these centers that provide outreach, temporary shelter, counseling, and aftercare services.

The federal government and the majority of the states have passed legislation aimed at combatting the rapidly growing problem of child pornography. Enactment of the Protection of Children Against Sexual Exploitation Act represents the first time a law extended authority to the federal government to: (1) prosecute both the producers and distributors of child pornography; (2) prohibit the transportation of children across state lines for the purpose of sexual exploitation; (3) punish anyone, including parents having custody or control of a minor, who knowingly permits a minor to participate in the production of such materials; (4) provide protection to males as well as females who are transported across state lines for the purpose of prostitution or engaging in sexual conduct for commercial exploitation; and (5) impose penalties of up to ten years imprisonment and fines up to $10,000 for the production and distribution of child pornographic materials.

National Programs

Computerized files maintained by the FBI National Crime Information Center (NCIC) consist of a Missing Person File and an Unidentified Person File. The Missing Person File is used to identify and locate missing persons, whereas the Unidentified Person File is used to identify the remains of deceased or unidentified living person by matching those records with missing reports. Among the unidentified living population are abducted and kidnapped children found in

the custody of adults who are not their legal guardians, runaway minors, amnesia victims, and homeless mentally disturbed persons. The Missing Person File contains about 44,000 records at any one time, 37,000 of which are juveniles. During calendar year 1984, 247,142 entries were made and 238,543 records, many from earlier years, were removed. Currently, the Unidentified Person File contains about 1,000 records. Some experts believe that FBI statistics reflect only a fraction of the actual number of missing children.

A packet of forms for missing and unidentified persons, developed by the NCIC, is available from local law enforcement agencies. The missing person forms should be completed by parents, in collaboration with physicians, dentists, and opticians, immediately after a child is reported as missing. These forms ask for information on physical characteristics of the missing person, jewelry descriptions, medical, dental, and optic identifying characteristics. Physicians interested in obtaining a copy of this packet can contact the FBI's National Crime Information Center in Washington, DC.[8]

The federal Runaway and Homeless Youth Program provides funding for shelters for runaways and homeless youth and their families. The program also operates a national hotline (1-800-621-4000), provides training and technical assistance, and funds demonstration projects.[1]

Shelters numbered 273 last year and served more than 300,000 youths, with 75,000 receiving shelter care for more than one night; 260,000 people were served by the national hotline. According to the US Department of Health and Human Services, more than half of the youth receiving services were reunited with their families, about six percent returned to the streets, and about 42 per cent were placed in some alternative living arrangement. In this population, there is an even distribution of females and males, the average age of the children is 15 years old. The principal reason for running away is conflict with parents.[9]

The National Center for Missing and Exploited Children (NCMEC), established in 1984 on a $3.3 million grant for two years from the Justice Department's Office of Juvenile Justice and Delinquency Prevention, has the primary task of backing up law enforcement agencies, families, state and local governments, and volunteer groups. A nonprofit corporation, the National Center operates a national resource and technical center that deals with child abductions, sexual exploitation, child pornography, and child prostitution.

Although NCMEC is not an investigative or a child recovery agency, it does provide extensive resources to assist in the recovery of children through its training and technical assistance programs. A toll-free 800 number is available for reporting abductions, sightings, and locations of missing children and adolescents. The National Center conducts training programs for law enforcement and social service professionals involved in the investigation and prosecution of cases of child victimization. Training assistance and advice are provided concerning liaison relationships with law enforcement agencies, families, health care providers, and various public and private organizations. Educational programs and materials have been developed on the prevention and handling of parental kidnapping cases, on the support services and resources available throughout the United States and Canada, and on state legislative initiatives.[5]

Health Problems

Many missing children have been abused and neglected in the home and take unattended physical and emotional health problems with them. For runaways and homeless youth, the street existence predisposes to exposure, illness, poor diet and hygiene, drug and alcohol abuse, and sexual abuse and exploitation. Common problems are skin infections, parasitic infections, sexually transmitted diseases, unwanted pregnancies, and respiratory and gastrointestinal disorders. Some of these young people do not receive immunizations against childhood diseases. Also found in this population are traumatic injuries ranging from minor to serious, from accidental or inflicted violence. Dental disease is rampant among children who have been on the streets.[10]

The same health problems and injuries that affect runaways and homeless youth occur in the abducted child population, especially those abducted for long periods of time. The major difference is that these young people are in the care of adults, some of whom, especially the noncustodial parent abductors, may be attentive to their health problems. However, since the parent has committed a crime by the act of abducting the child, the fugitive existence will most likely adversely affect the child's development.[11] Victims of abductions by strangers are at additional risk for health problems because most of their kidnappers have serious psychiatric illnesses or are motivated by financial gain only and may not be

able to take proper care of the child's health care needs.

Missing children, whether abducted, runaways or homeless, have usually gone through a lengthy period of family conflict marked by unhealthy marriages and a variety of adverse social and economic conditions profoundly affecting family stability. Common adversities are family disintegration, unemployment, poverty, substance abuse, divorce, cultural dislocation, single parenthood, and step families.[2] However, some children are abducted from a stable and healthy home environment. But, the act of child abduction by a stranger may seriously threaten family stability as each member of the family, reacts to the disappearance and mourns the loss of a loved one.

Any disappearance of a child or adolescent creates family disruption, emotional crisis, and vulnerability of the family members to physical and emotional problems. Parents may become inappropriately hostile and aggressive in their desperate search for the child, belabor themselves with guilt, feel helpless, and withdraw from normal family responsibilities and community supports. Parents of some runaways actually welcome the disappearance. These troubled families, often consumed by the attempt to find the missing child, may develop destructive family patterns characterized by anger, depression, isolation, chaotic lifestyles, and unproductive communication patterns. In this context, medical and social service interventions should focus not only on the runaway or the recovered victim of abduction, but on the entire troubled family. These interventions should be conducted over a long period of time in order to assess the recovery of the family unit from this tragedy. Family support groups are useful in identifying with the family's problems and offering practical advice and emotional support.

The Role of the Physician

Both public and private agencies provide services for runaway and homeless children. Abducted children and their families have fewer options for help. The past 15 years have seen a proliferation in the number of new agencies that provide temporary shelter care and offer child and family counseling to runaways and homeless youths. Some of these agencies have organized staff training programs, established relationships with hospitals, health care centers and clinics, and secured medical and psychiatric consultants.[2, 10] However, a significant number of them

Appendix

Recommendations for pediatricians and family physicians.

1. Identify blood group, ABO, and Rh on each newborn. Note any anatomical defects and birth injuries.
2. Obtain technically adequate birth footprints and fingerprints.
3. Incorporate mother's obstetrical history and blood group into the infant's chart and vise versa.
4. Flag all charts of children who are reported as missing or snatched and do not destroy them. Alert consultants and radiologists not to destroy their records. If records are requested, immediately notify the police agency investigating the disappearance.
5. Obtain records from previous pediatricians or family physicians, including x-ray films, x-ray reports, and laboratory studies.
6. Incorporate parental data such as social security number and employment description into the infant's record.
7. Include the name of the child's dentist in the record.
8. Describe in detail any anatomical scars, such as notched ears, abnormal toes, birthmarks, and scars.
9. Alert investigators of any suspicion of abuse or neglect.
10. Become familiar with the Unidentified and Missing Persons File format, developed and maintained by the FBI's National Crime Information Center.
11. Carefully record hair color, eye color, height and weight. This will help investigators project weights and heights for children who disappear and are retained by an abductor for several months or years.
12. Post suggestions for parents to keep careful health records and physical descriptions of their children as carefully as they would keep their tax records or business accounts.

Recommendations for obstetricians-gynecologists

1. Indicate blood group, ABO, and Rh on each newborn. Note any anatomical defects or birth injuries.
2. Obtain technically adequate birth footprints and fingerprints.
3. Incorporate mother's obstetrical history and blood group into the infant's chart and vise versa.

Recommendations for radiologists

1. Accurately describe foreign bodies and anatomical markers — shape, locations, and relationships to specific bony anatomical markers.
2. Retain the x-ray films of children until age 18.
3. Work with other professionals to develop procedures for prompt release of medical records and x-ray films to families and law enforcement officials.
4. Keep up to date on forensic radiologic methods in order to aid coroners and medical examiners.

operate without these essential supports for effective service to the child and family.

Physicians are in a special position to help missing and exploited children and their families because of their status in the community and their ongoing professional relationships with patients. Physicians can be highly effective in encouraging and supporting sound health programs and community-based prevention programs for disaffected youth, homeless, and abducted children. At prevention, diagnostic, and treatment levels, primary-care physicians and other specialists can identify troubled children and their families and ensure that appropriate medical interventions take place. Physicians should recognize that the responsibility for handling all of the health problems of these families is not theirs alone. The appropriate role for the physician is to serve as triage agent, connecting families with psychiatric and other medical specialists, family therapists, marriage and divorce counselors, other health care professionals, community agencies, and victim and family support groups.

Families in need of skilled assistance often do not know how to get the help they need. If physicians are aware of major family disruptions (eg, separation or divorce, child abuse, substance abuse, inappropriate disciplinary practices, or negative family interaction patterns), they can discuss these issues and recommend other sources of help for one or all of the family members. When a child is reported missing, the physician should contact the grieving parents and offer appropriate advice, counseling, and treatment referrals if necessary. Once the child is found or returned home, physicians caring for the individual members of the affected family should again initiate contacts and offer their advice and services to the family.

The ability of the physician to provide essential information to law enforcement officials regarding the identifying physical features and medical history of a patient who has been reported missing is crucial to the location of that child. The medical records, dental charts, and, for unidentified dead persons, the pathologist's findings are all essential to successful child-finding. The primary-care physician, medical examiner, and dentists are key members of the identification team. They should be prepared to complete the NCIC forms immediately after a child is reported missing.The physician would normally receive this form from a parent who has been instructed to return it to the police agency.

Families of missing persons usually obtain the NCIC missing person packet from the law enforcement agency to which they have made the missing person's report. The family completes the personal descriptors section, the jewelry type section, and, with the help of medical and dental professionals, the optic, medical, and dental section. If a family is unable to obtain a packet from the law enforcement agency taking the missing person's report or if the agency is unable to submit the information to the NCIC, then the family may request a copy of the missing person packet from the local FBI office and submit the completed forms directly to the FBI office.

Primary-care physicians, radiologists, and other physicians who see children on a regular basis should maintain a complete record of distinguishing characteristics and a comprehensive medical history for their child patients (see Appendix). Records should include information on blood group, details about anatomical defects, birth injuries and scars, birth footprints and fingerprints, hair and eye color, height and weight, evidence or suspicion of abuse or neglect, current and past records of laboratory studies, parental data such as social security number and employers, and x-ray films or well-delineated x-ray reports. Photographs are important documents to include in the health record. It is also important that obstetrician-gynecologists, pediatricians, and family physicians ensure that certain records be kept in duplicate; birth records and the record of the mother's obstetrical history and blood group should be prominent not only in the mother's file but repeated in the child's record.

Dried blood samples of a newborn taken for routine screening purposes could be retained in the child's record to provide other information for the identification of a missing or dead child. One method is to have an extra filter paper sample taken at the time the PKU and other screening tests are done. This extra blood sample could be kept in an envelope, retained with the child's medical record, and used in the future for checking minor blood group types should they be needed.

Physicians should be skeptical of vague stories about absent parents in cases involving newly transferred patients. Children who report parents who died mysteriously or children who report abandonments without good-bye letters, support payments, phone calls, or visitations may have been snatched.[12]

Although physicians should be concerned primarily with the health of children and their families, they should also focus attention on potential

or actual perpetrators of crimes, such as stranger-abductors and sexual abusers and exploiters. Primary care physicians should become adept at recognizing the signs and symptoms of pedophilia and psychopathic personalities who are predisposed to harming or exploiting children, and make certain that these patients come to the attention of a psychiatrist or psychiatric facility for definitive diagnosis and treatment.

Prevention

Physicians can be highly effective in community organization and implementation of sound health-oriented strategies of prevention. Their efforts should be aimed at reducing family stress, identifying early signs of alcoholism and drug abuse, and promoting development of community facilities to achieve these aims of supporting families at risk. Specific focuses should be family therapy, divorce and marriage counseling, drug and alcoholism prevention programs, and job training or retraining. Community outreach activities may embrace pre- and post-crisis prevention as well as youth participation programs that are oriented toward recreation and employment. Child advocacy and guardian ad litem programs for children involved in divorce and custody disputes are needed.[2]

Physicians should offer to participate in community-based prevention programs, lending their medical expertise and support to a team process. Schools, churches, and community and civic organizations are groups that the physician can potentially serve as an educator or medical expert.

Physicians are often in the best position to detect the early warning signs of families in distress and offer their assistance in achieving healthy living habits. They can also refer their patients to other appropriate professionals and to community agencies when necessary. Pediatricians, family physicians, and obstetrician-gynecologists have an excellent opportunity to use the birth of a child as an opportunity to discuss the role of parents in child development and positive child-rearing practices. All primary-care physicians should be knowledgeable and comfortable with discussing healthy sexual activities and the problems that parents have encountered in this area. If serious problems of sexuality are detected, the physician should refer both parents to a psychiatrist for assessment and treatment.

Medical professionals should be aware that any child who is the object of a custody dispute is vulnerable to parental snatching, disappearing, and being abused. It is incumbent upon the physician to recognize that family therapy and divorce and marriage counseling may be important child-sparing interventions. In this context, physicians may wish to support comprehensive health service programs as well as parent and victim support networks. Physicians can also offer professional guidance to these support groups.

Pediatricians and family physicians, serving families that either move from one location to another or change doctors within the same geographical area, should make certain that parents arrange for the speedy transfer of the child's previous medical records. Experts involved in locating missing children and tracking the movements of perpetrators urge that physicians adopt this as a requirement in their practice routines.

The dentist is another key member of the identification team. Pediatricians and family physicians should suggest to parents that children have their first dental examination at age three or even earlier because the full complement of deciduous teeth may be present as early as 24 months. In recent years, the dental profession has developed a microdisk that can be attached to the posterior teeth for identification purposes. The American Dental Association's Council on Dental Practice is studying various types of microdisks and the feasibility of establishing a central clearinghouse for storage of microdisk information. In addition, the ADA has established the American Dental Identification Registry, which will advise on the protocol for community service activities related to microdisk placement.

Research Issues

Research shows that parents of children who run away face multiple social and psychological difficulties. The clearest empirical finding is a lack of parental consistency in handling their children and the consequent lack of effectiveness in managing the child's behavior in a way that promotes psychological and social development. Another common characteristic is unrealistic expectations by the parents of what constitutes appropriate behavior for their child. Research further reveals a high degree of strain in these families, with family interaction patterns that are primarily negative. Generally, runaways have unsatisfactory interpersonal relationships with both peers and adults.[13-19]

Parental divorce is common in the background of runaways and abducted children. The fact that one million children are involved in new divorces each year and that one-third of all US children will be involved in a family dissolution before

they are 18 years of age underscores the need for more sound research in this area.[20]

Children of divorce who are living at home may view the dissolution of their parents' marriage as the most distressful event in their lives. Emotional upsets, rather than physical hardships or logistical changes in the family living arrangements and child care patterns, usually constitute the most severe problems for children. The divorce is experienced by most children as an overwhelming event and often one for which they feel vaguely responsible. Loyalty conflicts — as well as feelings of anger, fear, grief, helplessness, and guilt — are common in children of divorce.[21-23]

A substantial body of both clinical and research literature shows that most children experience their parents' divorce as a stressful life event and exhibit short-term developmental disruptions, emotional distress, and behavior disorders. In the first few years following divorce, children in divorced families in comparison to children in nondivorced families show more antisocial, impulsive acting-out disorders, more aggression and noncompliance, more dependency, anxiety, and depression, more difficulties in social relationships, and more problem behaviors at school. Impulsive antisocial behavior is more consistently reported than withdrawal, depression, and anxiety. Overall effects of divorce are more severe and enduring for boys than for girls, although problems in heterosexual relationships have been reported for adolescent and young adult girls. Since most of the studies comparing the responses of sons and daughters to divorce have have involved preadolescents, it may be that the differing effects of divorce on boys and girls are more marked in younger than in older children. Although differences in academic achievement and cognitive development are sometimes reported, they are not as consistently found and are greatly attentuated when the effects of social class are controlled.[24]

From a series of studies on children of marital discord and divorce, the preponderance of evidence points to parental conflict and disagreement as associated with problems of undercontrol (eg, aggression, conduct disorders, and delinquency), especially in boys. Moreover, the longer the marital disharmony, the greater the risk to the child. Only a few findings have indicated that marital conflict is associated with disorders of overcontrol (eg, neurotic problems) or that it adversely affects girls to the same extent as boys. To date, there is no clear evidence that suggests that parental conflict differentially affects children at different developmental stages.[20]

Definitive studies have not been conducted on the impact of parental abductions or stranger abductions on the victims. However, in Terr's study of 18 children kidnapped successfully or abortively by a parent, emotional effects were evident in 16 of the youngsters. The children demonstrated the following functional conditions: (1) after effects of severe fright or psychic trauma; (2) effects of mental indoctrination; (3) grief or rage about parental abandonment; (4) rejection of the offending parent; and (5) exaggerated identification with a parent or wish fulfillment about a parent. These emotional disturbances occurred in the 16 affected children whether the kidnapping was successful, the law sanctioned their snatching, it was a first or second snatching, or the parents or court defined the experiences as a "vacation." The two children who exhibited no direct psychiatric effects from the successful snatching by their fathers had been told the truth from the beginning, maintained phone contact and visitations with their mothers during their stay with their fathers, and continued to be exposed to so many different lifestyles that the kidnapping seemed like just another episode in their disorganized young lives.[12]

Educational Opportunities

At every level of medical education, physicians should be exposed to concepts regarding the diagnosis, comprehensive treatment, and prevention of problems associated with family stress and disorganization. These problems may stem from economic distress, alcoholism, drug abuse, ineffective parenting, marital discord, or divorce. Physician training programs should incorporate methods of liaison and other communication with relevant specialists, both medical and nonmedical. Physicians should be exposed early to the concept and practice of multidisciplinary treatment teams, both where the physician functions as a team leader and of the type where his role is participatory or consultative. Practicing physicians, academicians, medical students, and residents should have exposure to courses that deal with the comprehensive treatment of families under stress. Medical students, residents, and practicing physicians should be alerted to their own psychiatric vulnerabilities in dealing with families under stress and be encouraged to promote educational programs that cover this material.

Continuing medical education programs for

primary-care physicians should be designed to include material on (1) interviewing skills; (2) family dynamics and developmental influences throughout the life cycle, including the impact of death or severe loss on the family; (3) initial assessment and evaluation of the patient and family under stress, with emphasis on the physician's responsibility; (4) realistic assessment of the goals of treatment; (5) the latest research findings on child abuse and neglect, alcoholism and drug abuse, the effects of divorce and unemployment on the family; and (6) how to use psychiatric and other forms of consultation effectively, including community resources outside of traditional medicine.

Physicians should participate in educational programs that have an interdisciplinary focus. Also, training programs should encourage physicians to continue to monitor their patients in the community after referral to medical or nonmedical specialists and community resources.

Activities of Other Organizations

In the past year, the College of American Pathologists (CAP) has launched a Missing Children Project. Following announcement of the project, the college prepared and distributed a questionnaire to CAP members asking for information on the number of unidentified dead persons processed during calendar year 1983. Survey results will be published in a future issue of the *Pathologist*, the college's official publication. In addition, an advisory describing the FBI's National Crime Information Center, how to use it, and why pathologists should file all information concerning unidentified dead persons has been sent to the CAP membership. Other components of the project that are in various stages of development include a handbook that presents specific directions concerning the autopsy and methods to identify unknown deceased persons and how to complete the NCIC forms; a Missing Children's Project exhibit displayed at the college's annual meeting; workshops directed to the pathologist who is not regularly involved with autopsies; and several articles published in the May 1985 issue of the *Pathologist*.

The American Academy of Pediatrics has had a longstanding concern with missing children issues and is currently reviewing a policy statement that will be helpful to pediatricians in identifying high-risk populations, treating the victims, and counseling the families.

As stated earlier, the American Dental Association is evaluating various types of microdisks that can be attached to the posterior teeth for identification purposes. Protocols for microdisk placement are promoted in community service programs and other ADA activities.

Conclusion

Child abductions and runaway behaviors are harmful and emotionally upsetting, divisive, and chaos-producing to victims and their families. Any disappearance of a child constitutes a family crisis with both victims and families at high risk for developing physical and emotional problems. Any child who is the object of a custody dispute is vulnerable to parental snatching, running away, or being abused. Medical interventions, including family therapy, should occur immediately after a child is reported missing. If the child returns home or is found dead, physicians and other health care professionals should continue to monitor the victim patient and the patient's family.

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HAVE YOU HEARD?

A study from Israel reveals an average annual incidence of presenile dementia of the Alzheimer type of 2.4 per 100,000 persons between the ages of 40 and 60. The epidemiologic survey showed that the age of onset of identified patients ranged from 43 to 60 years, and that the median survival was 8.1 years. The incidence was "significantly higher in those born in Europe or America (2.9) than in those born in Africa or Asia," report Doctor Therese M. Treves and her colleagues from Tel Aviv University in the January 1986 issue of the *Archives of Neurology*. The nationwide survey was conducted between the years of 1974 and 1983, and identified a total of 71 patients with onset between 1974 and 1978.

• • •

Body build is the major determinant of kidney weight and nephron size in normal human beings, according to a report in the January 1986 issue of the *Archives of Laboratory Medicine and Pathology*. Previous studies have suggested that age, race, or sex are the major determinants of kidney weight, which ranged from 267 g to 432 g in adult men. Doctor Bertram L. Kasiaske and Andrew J. Umen of the University of Minnesota examined kidney weight in 357 normal individuals who died suddenly. "The present study demonstrated that normal kidney weight was best predicted by descriptions of body build that combined height and weight," they conclude. Understanding of normal kidney weight will aid managment of patients with renal disease.

• • •

A study from McLean Hospital in Belmont, Massachusetts suggests that strict adherence to dosage guidelines will decrease the incidence of seizures associated with the use of maprotiline hydrochloride, a second generation antidepressant introduced in the United States in 1981. "Maprotiline is an effective antidepressant, as effective as the standard tricyclics, and perhaps less likely to cause other adverse reactions," observed Doctor Eric C. Dessain and his colleagues in the January 1986 issue of the *Archives of General Psychiatry*. Their study suggests that seizure rates can be cut in half by, among other things, never exceeding a dosage level of 225 mg per day.

• • •

Appropriate thyroid therapy may result in increased bone loss, according to a study by Doctor Jean-Michel Coindre and his colleagues at the



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Universite de Bordeaux in France. The researchers studied 16 patients under treatment for hypothyroidism. "After six months of treatment, there was a significant loss of trabecular and cortical bone," they report in the January 1986 issue of the *Archives of Internal Medicine*. "This osteoporosis is similar to that observed in hyperthyroidism," they add. Commenting editorially, Doctor Horace M. Perry III of the St. Louis University School of Medicine suggests that calcium and vitamin D be included in the treatment of hypothyroidism.

• • •

A study from the University of Utah Medical Center offers powerful evidence that genetic factors associated with coronary heart disease can be overcome. Studied were descendents of four pioneer males with dominant familial hypercholesterolemia. The average cholesterol level for grandsons was 352 mg/dL and the average age at death from coronary heart disease was 45 years. One grandson, however, was able to reduce his cholesterol level from 426 to 248 mg/dL, "with strict adherence to a low-fat diet without drugs," reports Doctor Roger R. Williams and his colleagues in the January 3, 1986 issue of *JAMA*. All of the pioneer forebears lived beyond 60, suggesting that a physically active life offers protection against early coronary death, despite genetic predisposition.

• • •

The Random Dot E stereogram method for vision screening is "more effective than five of six other techniques in identifying those children who need further visual screening," report Doctors Robert S. Hammond and Paulette P. Schmidt of Ohio State University in Columbus in the January 1986 issue of the *Archives of Ophthalmology*. Moreover, the method can be taught to nonprofessional screeners in ten minutes and administered to children in two minutes at relatively low cost. Commenting editorially, Doctor Robert D. Reinecke of Philadelphia notes, "There is no doubt that the earlier that children with amblyopia and strabismus are referred for therapy, the better the prognosis." He urges mass screening before school age; currently only 20 per cent of all school children are screened.

• • •

Recipients of kidney transplants are at high risk for cerebrovascular disease, according to a report in the February 1986 issue of the *Archives of Neurology*. Records of 467 transplant patients at the University of Iowa Hospitals in Iowa City were

reviewed by Doctor Harold P. Adams and his colleagues. "We found that vascular diseases accounted for 25 per cent of deaths in our population, but stroke-related deaths were few," they say. "Despite the low mortality due to stroke, cerebrovascular events were common (9.5 per cent) and were a frequent cause of disability," they add. The incidence of such events may be increased as much as 300-fold, with diabetic patients over age 40 at particular risk.

• • •

Low-dose estrogen therapy rapidly stimulated growth hormone production, according to a study from the University of Chicago Pritzker School of Medicine that appears in the February 1986 *American Journal of Diseases of Children*. Doctor George William Moll, Jr. and his colleagues studied 23 short, prepubertal children, administering levadopa tests before and after being treated with ethinyl estradiol. One low bedtime dose resulted in a significant increase in growth hormone levels, with no significant change in somtomedin-C levels, the researchers report. "This action may be important for the stimulation of growth by estrogen," they conclude.

• • •

Transplant chemistry costs at the University of Pittsburgh School of Medicine zoomed from $47,000 per year to $1.2 million in the four years following the arrival of surgeon Thomas Starzl, reports Doctor Ajit Sanghvi in the February 1986 issue of the *Archives of Pathology and Laboratory Medicine*. "The number of transplant-related clinical chemistry procedures, primarily cyclosporine and liver and renal function tests, increased from 1.4 per cent of the total chemistry tests in 1979-1980 to 21 per cent of the total tests in 1983-1984," Sanghvi says, and adds, "These data quantify the level of laboratory support that is required to sustain a viable and ambitious organ transplant program."

• • •

Osteoporosis affects at least 15 million Americans. Fortunately, individuals can reduce their risk by recognizing and modifying risk factors, according to the new report *Osteoporosis*, published by the American Council on Science and Health (ACSH). The Council is an independent, nonprofit consumer education organization promoting scientifically-balanced evaluations of food, chemicals, environment, and health.

"Osteoporosis discriminates by both race and

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sex. Whites have a higher risk than blacks, and women a higher risk than men. Although the problem usually does not appear until rather late in life, after menopause in the case of women, preventive measures are important even for young adults." The Council recommends adequate dietary calcium, regular physical activity, and avoidance of tobacco and alcohol abuse.

"Most of us do not get enough calcium in our diets; a recent government study showed that 80 per cent of adult women consume less than the recommended amount of calcium," said ACSH Research Associate Kathleen Meister, author of the ACSH report. "Milk and other dairy products are the principal sources of calcium in our food supply; they provide more than 70 per cent of our total calcium. You can add calcium in your diet without adding excessive amounts of fat and calories by selecting skim or lowfat milk, lowfat yogurt, and cheese."

While estrogen therapy administered after menopause has been shown to be effective in retarding or preventing the bone loss of osteoporosis, it has risks and side effects and is not suitable for every woman, the ACSH report states. Women who undergo surgical removal of the ovaries before menopause are at particularly high risk and should receive estrogen therapy unless there is a definite medical contraindication.

• • •

Air bags should be available as an option on new cars and should be used in addition to lap-and-shoulder safety belts, according to a new report by the American Council on Science and Health (ACSH). The Council is an independent, nonprofit consumer education organization promoting scientifically balanced evaluations of food, chemicals, the environment, and health.

"Many people are killed or injured unnecessarily in traffic accidents because they are not protected by any restraint system. The use of either seat belts or air bags could prevent many of these tragedies. However, the quickest and least expensive solution to this problem is to make sure that people use the safety belts that are already present in their automobiles," said ACSH Research Associate Sharon Lynn Campbell, author of the report *Automobile Occupant Restraint Systems.*

"Safety belts have been proven effective in reducing death and injuries," Ms. Campbell said, and added, "Several states now require their use, and we think that these laws are reasonable. In those states and foreign countries where mandatory seat belt use laws have been introduced

and adopted, seat belt use has increased substantially, and traffic fatalities have dropped."

Because of their expense, the Council recommends that air bags not be required on all new cars. Moreover, since air bags offer protection only in frontal crashes and not in rear-end, broadside, or rollover collisions, they should not be regarded as an alternative of seat belts.

All fifty states and the District of Columbia now require that infants and small children be protected by federally-approved child restraints when they ride in automobiles. "Child safety seats are crucial for the protection of infants and small children," Ms. Campbell said. "The number one killer of children is automobile collisions, and children are at much greater risk of being killed or seriously injured in a crash if they are unrestrained. Children are even more likely to be hurt than adults are, because they are top-heavy and thus at risk of serious head and spinal injuries. Adult seat belts are designed for an adult's center of gravity and do not provide adequate protection for small children."

• • •

A controlled study from the University of Arkansas College of Medicine in Little Rock suggests that human subjects can control their immune response to some viral challenges. Tested in a three-part study was the response of a person practiced in meditation to skin exposure to varicella zoster. "The data confirmed that this subject could voluntarily modulate her immune response by a psychic mechanism," say Dr. Richard G. Smith and his colleagues in the November 1985 issue of the *Archives of Internal Medicine*. "It appears that the subject, acting with intention, was able to affect not only her skin test response but also the response of her lymphocyte studies in the laboratory."

• • •

The new use of a compound long associated with psoriasis has "rendered better cosmetic results," according to a study in the December 1985 issue of the *Archives of Dermatology*. Doctors Thomas Schwarz and Fritz Gschnait of City Hospital Vienna-Lainz in Austria report that anthralin cream applied to the entire body for five-minute treatments resulted in complete clearing in 72 per cent of a study group, and marked improvement in an additional five per cent. Anthralin has been used for psoriasis since 1916. The entire body treatment removes lesions without "spotty hyperpigmentation" and leaves a generalized tan, the researchers say.

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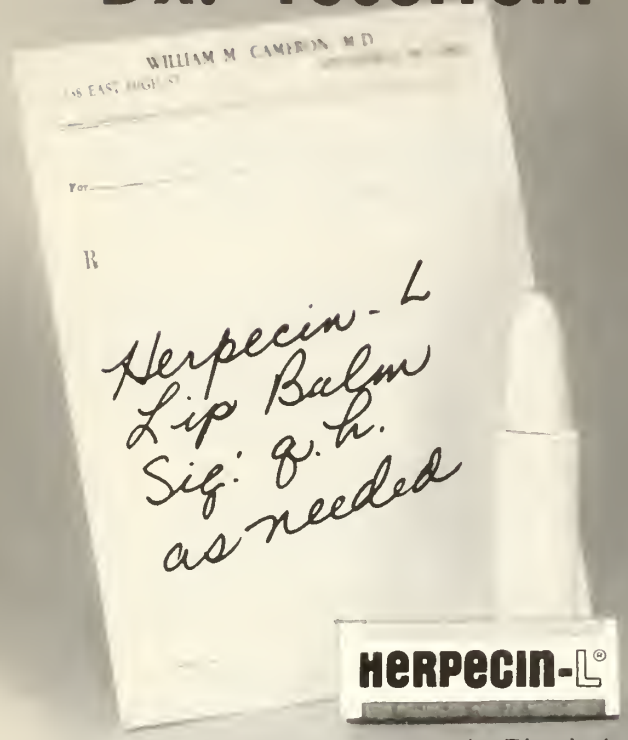
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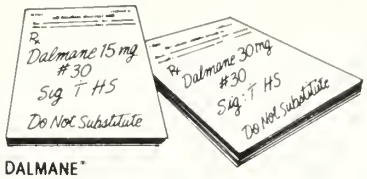
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References: **1.** Kales J, *et al. Clin Pharmacol Ther 12* 691-697, Jul-Aug 1971 **2.** Kales A, *et al Clin Pharmacol Ther 18* 356-363, Sep 1975 **3.** Kales A, *et al. Clin Pharmacol Ther 19* 576-583, May 1976 **4.** Kales A, *et al Clin Pharmacol Ther 32* 781-788, Dec 1982 **5.** Frost JD Jr, DeLucchi MR *J Am Geriatr Soc 27* 541-546, Dec 1979 **6.** Dement WC, *et al. Behav Med*, pp 25-31, Oct 1978 **7.** Kales A, Kales JD *J Clin Psychopharmacol 3* 140-150, Apr 1983 **8.** Tennant FS, *et al:* Symposium on the Treatment of Sleep Disorders, Teleconference, Oct 16, 1984 **9.** Greenblatt DJ, Allen MD, Shader RI. *Clin Pharmacol Ther 21* 355-361, Mar 1977



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Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase, and paradoxical reactions, *e.g.* excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect. *Adults*: 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients*: 15 mg recommended initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

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Rhode Island Medical Journal

September 1986
Volume 69, Number 9

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DR. CALEB FISKE HOMESTEAD

CONTRIBUTIONS

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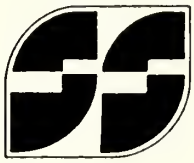
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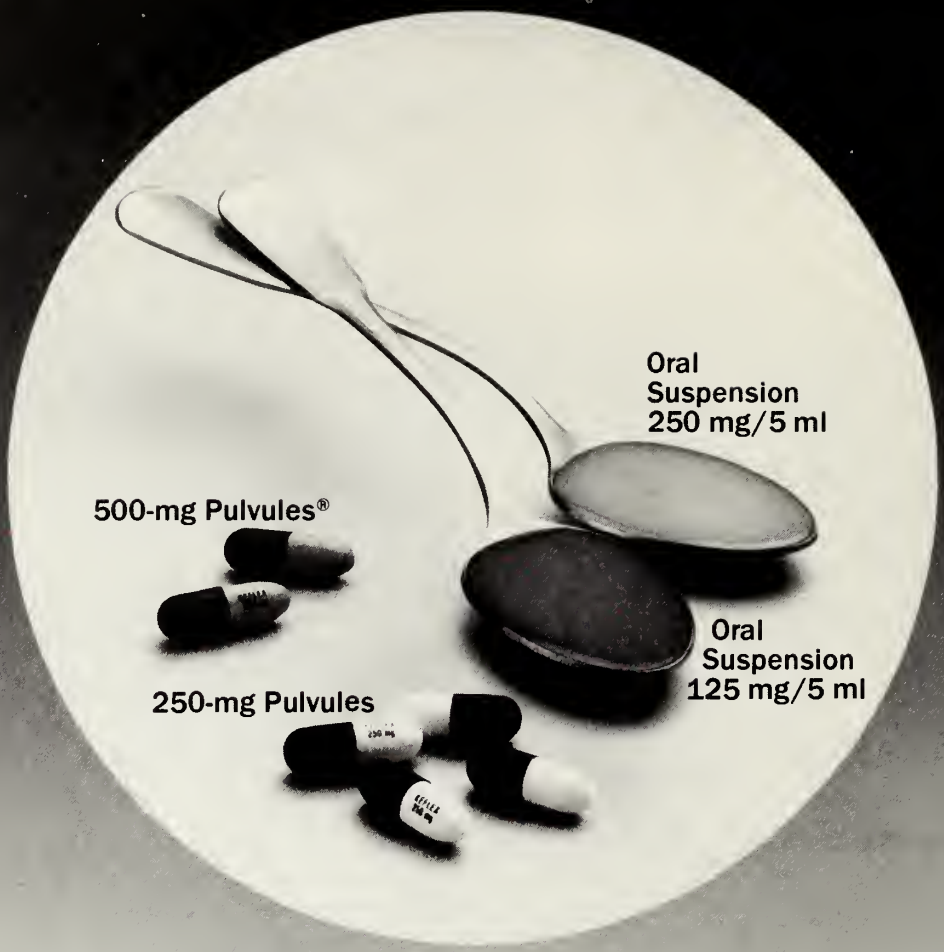
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There's never been a better time for her... and PREMARIN®
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Significantly reduced risk of endometrial hyperplasia

Endometrial hyperplasia was significantly reduced when progestin was added to PREMARIN therapy for more than ten days a month.[1-4] The risk of endometrial hyperplasia may also be reduced through cyclic administration of unopposed, low-dose PREMARIN.

Effect on lipids—an important feature

PREMARIN used alone does not adversely affect lipid levels. In fact, a clinical study has shown a significant increase in HDL cholesterol—from 49.7 mg/dL to 56.4 mg/dL—and decrease in LDL cholesterol—from 165.1 mg/dL to 138.1 mg/dL—after one year of therapy with PREMARIN, 0.625 mg.[5]

Low-dose control of menopausal symptoms*

PREMARIN effectively relieves vasomotor symptoms, such as hot flashes. When estrogen deficiency is limited to atrophic vaginitis, PREMARIN® (conjugated estrogens) Vaginal Cream restores the vaginal environment to its premenopausal state.

The most widely used, most extensively studied estrogen worldwide.

PREMARIN®
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Most trusted for more reasons

*PREMARIN is indicated for moderate-to-severe vasomotor symptoms.

Please see following page for brief summary of prescribing information.

For moderate-to-severe vasomotor symptoms

PREMARIN®
(Conjugated Estrogens Tablets)



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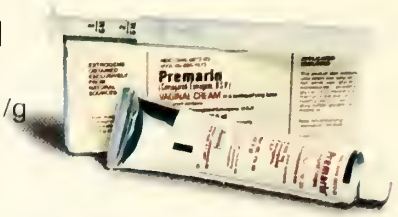
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For atrophic vaginitis

PREMARIN®
(Conjugated Estrogens)

Vaginal Cream

0.625mg/g



BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION AND PATIENT INFORMATION, SEE PACKAGE CIRCULARS.)*

PREMARIN® Brand of conjugated estrogens tablets, USP
PREMARIN® Brand of conjugated estrogens Vaginal Cream in a nonliquefying base

1. ESTROGENS HAVE BEEN REPORTED TO INCREASE THE RISK OF ENDOMETRIAL CARCINOMA

Three independent case control studies have reported an increased risk of endometrial cancer in postmenopausal women exposed to exogenous estrogens for more than one year. This risk was independent of the other known risk factors for endometrial cancer. These studies are further supported by the finding that incidence rates of endometrial cancer have increased sharply since 1969 in eight different areas of the United States with population-based cancer reporting systems, an increase which may be related to the rapidly expanding use of estrogens during the last decade. The three case control studies reported that the risk of endometrial cancer in estrogen users was about 4.5 to 13.9 times greater than in nonusers. The risk appears to depend on both duration of treatment and on estrogen dose. In view of these findings, when estrogens are used for the treatment of menopausal symptoms, the lowest dose that will control symptoms should be utilized and medication should be discontinued as soon as possible. When prolonged treatment is medically indicated, the patient should be reassessed on at least a semiannual basis to determine the need for continued therapy. Although the evidence must be considered preliminary, one study suggests that cyclic administration of low doses of estrogen may carry less risk than continuous administration; it therefore appears prudent to utilize such a regimen. Close clinical surveillance of all women taking estrogens is important. In all cases of undiagnosed persistent or recurring abnormal vaginal bleeding, adequate diagnostic measures should be undertaken to rule out malignancy. There is no evidence at present that "natural" estrogens are more or less hazardous than "synthetic" estrogens at equiestrogenic doses.

2. ESTROGENS SHOULD NOT BE USED DURING PREGNANCY

The use of female sex hormones, both estrogens and progestogens, during early pregnancy may seriously damage the offspring. It has been shown that females exposed in utero to diethylstilbestrol, a non-steroidal estrogen, have an increased risk of developing in later life a form of vaginal or cervical cancer that is ordinarily extremely rare. This risk has been estimated as not greater than 4 per 1,000 exposures. Furthermore, a high percentage of such exposed women (from 30% to 90%) have been found to have vaginal adenosis, epithelial changes of the vagina and cervix. Although these changes are histologically benign, it is not known whether they are precursors of malignancy. Although similar data are not available with the use of other estrogens, it cannot be presumed they would not induce similar changes. Several reports suggest an association between intrauterine exposure to female sex hormones and congenital anomalies, including congenital heart defects and limb reduction defects. One case control study estimated a 4.7-fold increased risk of limb reduction defects in infants exposed in utero to sex hormones (oral contraceptives, hormone withdrawal tests for pregnancy, or attempted treatment for threatened abortion). Some of these exposures were very short and involved only a few days of treatment. The data suggest that the risk of limb reduction defects in exposed fetuses is somewhat less than 1 per 1,000. In the past, female sex hormones have been used during pregnancy in an attempt to treat threatened or habitual abortion. There is considerable evidence that estrogens are ineffective for these indications, and there is no evidence from well controlled studies that progestogens are effective for these uses. If PREMARIN is used during pregnancy, or if the patient becomes pregnant while taking this drug, she should be apprised of the potential risks to the fetus, and the advisability of pregnancy continuation.

DESCRIPTION: PREMARIN (conjugated estrogens, USP) contains a mixture of estrogens, obtained exclusively from natural sources, blended to represent the average composition of material derived from pregnant mares' urine. It contains estrone, equilin, and 17α-dihydroequilin, together with smaller amounts of 17α-estradiol, equilenin, and 17α-dihydroequilenin as salts of their sulfate esters. Tablets are available in 0.3 mg, 0.625 mg, 0.9 mg, 1.25 mg, and 2.5 mg strengths of conjugated estrogens. Cream is available as 0.625 mg conjugated estrogens per gram.

INDICATIONS AND USAGE: PREMARIN (conjugated estrogens tablets, USP): Moderate-to-severe *vasomotor* symptoms associated with the menopause. (There is no evidence that estrogens are effective for nervous symptoms or depression without associated vasomotor symptoms and they should not be used to treat such conditions.) **Osteoporosis (abnormally low bone mass).** Atrophic vaginitis. Kraurosis vulvae. Female castration.

PREMARIN (conjugated estrogens) Vaginal Cream is indicated in the treatment of atrophic vaginitis and kraurosis vulvae. PREMARIN HAS NOT BEEN SHOWN TO BE EFFECTIVE FOR ANY PURPOSE DURING PREGNANCY AND ITS USE MAY CAUSE SEVERE HARM TO THE FETUS (SEE BOXED WARNING).

Concomitant Progestin Use: The lowest effective dose appropriate for the specific indication should be utilized. Studies of the addition of a progestin for 7 or more days of a cycle of estrogen administration have reported a lowered incidence of endometrial hyperplasia. Morphological and biochemical studies of the endometrium suggest that 10 to 13 days of progestin are needed to provide maximal maturation of the endometrium and to eliminate any hyperplastic changes. Whether this will provide protection from endometrial carcinoma has not been clearly established. There are possible additional risks which may be associated with the inclusion of progestin in estrogen replacement regimens. (See PRECAUTIONS.) The choice of progestin and dosage may be important; product labeling should be reviewed to minimize possible adverse effects.

CONTRAINDICATIONS: Estrogens should not be used in women (or men) with any of the following conditions: 1. Known or suspected cancer of the breast except in appropriately selected patients being treated for metastatic disease. 2. Known or suspected estrogen-dependent neoplasia. 3. Known or suspected pregnancy (See Boxed Warning). 4. Undiagnosed abnormal genital bleeding. 5. Active thrombophlebitis or thromboembolic disorders. 6. A past history of thrombophlebitis, thrombosis, or thromboembolic disorders associated with previous estrogen use (except when used in treatment of breast or prostatic malignancy).

WARNINGS: Long-term continuous administration of natural and synthetic estrogens in certain animal species increases the frequency of carcinomas of the breast, cervix, vagina, and liver. There are now reports that estrogens increase the risk of carcinoma of the endometrium in humans. (See Boxed Warning.) At the present time there is no satisfactory evidence that estrogens given to postmenopausal women increase the risk of cancer of the breast, although a recent study has raised this possibility. There is a need for caution in prescribing estrogens for women with a strong family history of breast cancer or who have breast nodules, fibrocystic disease, or abnormal mammograms. A recent study has reported a 2- to 3-fold increase in the risk of surgically confirmed gallbladder disease in women receiving postmenopausal estrogens.

Adverse effects of oral contraceptives may be expected at the larger doses of estrogen used to treat prostatic or breast cancer or postpartum breast engorgement, it has been shown that there is an increased risk of thrombosis in men receiving estrogens for prostatic cancer and women for postpartum breast engorgement. Users of oral contraceptives have an increased risk of diseases, such as thrombophlebitis, pulmonary embolism, stroke, and myocardial infarction. Cases of retinal thrombosis, mesenteric thrombosis, and optic neuritis have been reported in oral contraceptive users. An increased risk of postsurgery thromboembolic complications has also been reported in users of oral contraceptives. If feasible, estrogen should be discontinued at least 4 weeks before surgery of the type associated with an increased risk of thromboembolism, or during periods of prolonged immobilization. Estrogens should not be used in persons with active thrombophlebitis, thromboembolic disorders, or in persons with a history of such disorders in association with estrogen use. They should be used with caution in patients with cerebral vascular or coronary artery disease. Large doses (5 mg conjugated estrogens per day), comparable to those used to treat cancer of the prostate and breast, have been shown to increase the risk of nonfatal myocardial infarction, pulmonary embolism and thrombophlebitis. When doses of this size are used, any of the thromboembolic and thrombotic adverse effects should be considered a clear risk.

Benign hepatic adenomas should be considered in estrogen users having abdominal pain and tenderness, abdominal mass, or hypovolemic shock. Hepatocellular carcinoma has been reported in women taking estrogen-containing oral contraceptives. Increased blood pressure may occur with use of estrogens in the menopause and blood pressure should be monitored with estrogen use. A worsening of glucose tolerance has been observed in patients on estrogen-containing oral contraceptives. For this reason, diabetic patients should be carefully observed. Estrogens may lead to severe hypercalcemia in patients with breast cancer and bone metastases.

PRECAUTIONS: Physical examination and a complete medical and family history should be taken prior to the initiation of any estrogen therapy with special reference to blood pressure, breasts, abdomen, and pelvic organs, and should include a Papanicolaou smear. As a general rule, estrogen should not be prescribed for longer than one year without another physical examination being performed. Conditions influenced by fluid retention such as asthma, epilepsy, migraine, and cardiac or renal dysfunction, require careful observation. Certain patients may develop manifestations of excessive estrogenic stimulation, such as abnormal or excessive uterine bleeding, mastodynia, etc. Prolonged administration of unopposed estrogen therapy has been reported to increase the risk of endometrial hyperplasia in some patients. Oral contraceptives appear to be associated with an increased incidence of mental depression. Patients with a history of depression should be carefully observed. Preexisting uterine leiomyomata may increase in size during estrogen use. The pathologist should be advised of estrogen therapy when relevant specimens are submitted. If jaundice develops in any patient receiving estrogen, the medication should be discontinued while the cause is investigated. Estrogens should be used with care in patients with impaired liver function, renal insufficiency, metabolic bone diseases associated with hypercalcemia, or in young patients in whom bone growth is not complete. If concomitant progestin therapy is used, potential risks may include adverse effects on carbohydrate and lipid metabolism.

The following changes may be expected with larger doses of estrogen:

a. Increased sulfobromophthalein retention.

b. Increased prothrombin and factors VII, VIII, IX, and X, decreased antithrombin 3, increased norepinephrine-induced platelet aggregability.

c. Increased thyroid binding globulin (TBG) leading to increased circulating total thyroid hormone, as measured by PBI, T4 by column, or T4 by radioimmunoassay. Free T3 resin uptake is decreased, reflecting the elevated TBG; free T4 concentration is unaltered.

d. Impaired glucose tolerance.

e. Decreased pregnanediol excretion.

f. Reduced response to metyrapone test.

g. Reduced serum folate concentration.

h. Increased serum triglyceride and phospholipid concentration. As a general principle, the administration of any drug to nursing mothers should be done only when clearly necessary since many drugs are excreted in human milk.

ADVERSE REACTIONS: The following have been reported with estrogenic therapy, including oral contraceptives: breakthrough bleeding, spotting, change in menstrual flow, dysmenorrhea, premenstrual-like syndrome, amenorrhea during and after treatment; increase in size of uterine fibromyomata; vaginal candidiasis, change in cervical erosion and in degree of cervical secretion; cystitis-like syndrome; tenderness, enlargement, secretion (of breasts); nausea, vomiting, abdominal cramps, bloating; cholestatic jaundice; chloasma or melasma which may persist when drug is discontinued; erythema multiforme; erythema nodosum; hemorrhagic eruption; loss of scalp hair; hirsutism; steepening of corneal curvature; intolerance to contact lenses; headache, migraine, dizziness, mental depression, chorea; increase or decrease in weight; reduced carbohydrate tolerance; aggravation of porphyria, edema, changes in libido.

ACUTE OVERDOSAGE: May cause nausea, and withdrawal bleeding may occur in females.

DOSAGE AND ADMINISTRATION:

PREMARIN® Brand of conjugated estrogens tablets, USP

1. *Given cyclically for short-term use only.* For treatment of moderate to severe *vasomotor* symptoms, atrophic vaginitis, or kraurosis vulvae associated with the menopause (0.3 to 1.25 mg or more daily). The lowest dose that will control symptoms should be chosen and medication should be discontinued as promptly as possible. Administration should be cyclic (eg, three weeks on and one week off). Attempts to discontinue or taper medication should be made at three- to six-month intervals.

2. *Given cyclically.* Female castration. Osteoporosis. Female castration—1.25 mg daily, cyclically. Adjust upward or downward according to response of the patient. For maintenance, adjust dosage to lowest level that will provide effective control. Osteoporosis—0.625 mg daily. Administration should be cyclic (eg, three weeks on and one week off).

Patients with an intact uterus should be monitored for signs of endometrial cancer and appropriate measures taken to rule out malignancy in the event of persistent or recurring abnormal vaginal bleeding.

PREMARIN® Brand of conjugated estrogens Vaginal Cream

Given cyclically for short-term use only. For treatment of atrophic vaginitis or kraurosis vulvae.

The lowest dose that will control symptoms should be chosen and medication should be discontinued as promptly as possible.

Administration should be cyclic (eg, three weeks on and one week off).

Attempts to discontinue or taper medication should be made at three-to-six month intervals.

Usual dosage range: 2 to 4 g daily, intravaginally, depending on the severity of the condition.

Treated patients with an intact uterus should be monitored closely for signs of endometrial cancer and appropriate diagnostic measures should be taken to rule out malignancy in the event of persistent or recurring abnormal vaginal bleeding.

References:

1. Whitehead MI, Townsend PT, Pryse-Davies J, et al: Effects of estrogens and progestins on the biochemistry and morphology of the postmenopausal endometrium. *N Engl J Med* 1981;305:1599-1605. **2.** Paterson MEL, Wade-Evans T, Sturdee DW, et al: Endometrial disease after treatment with oestrogens and progestogens in the climacteric. *Br Med J* 1980;280:822-824. **3.** Magos AL, Brincat M, Studd JWW, et al: Amenorrhea and endometrial atrophy with continuous oral estrogen and progestogen therapy in postmenopausal women. *Obstet Gynecol* 1985;67:496-499. **4.** Whitehead MI, Lane G, Siddle N, et al: Avoidance of endometrial hyperstimulation in estrogen-treated postmenopausal women. *Semin Reprod Endocrinol* 1983;1:1;41-52. **5.** Barnes RB, Roy S, Lobo RA: Comparison of lipid and androgen levels after conjugated estrogen or depo-medroxyprogesterone acetate treatment in postmenopausal women. *Obstet Gynecol* 1985;66:216-219.

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Newsletter

RHODE ISLAND MEDICAL JOURNAL
September 1986

Peter D T Clarisse, MD, President
Jack A Perkins, Editor

BLUES "PRUDENT BUYER POLICY"

Rhode Island Medical Society President Peter D T Clarisse, MD, recently received clarifications to a series of questions raised by the new Blue Cross and Blue Shield (BC/BS) "Prudent Buyer Policy." In an exchange of letters with Ronald Battista, Vice President BC/BS, President Clarisse sought and received information to help clarify the options available to physicians. The announcements by BC/BS to unilaterally amend all Participating Contracts has been a source of concern and confusion for RIMS members. The BC/BS action has also prompted an investigation by the US Department of Justice.

The change in the Participating Contracts to include the new "Prudent Buyer Policy" would result in a significant alteration of current payment practices. The amended plan is the result of the following policy statements approved by BC/BS:

1. The plan will not pay a provider more for a service, procedure or product than that provider is accepting as payment in full from any other buyer; and
2. The plan will not offer a payment mechanism to any provider which is more favorable than an arrangement that provider has entered into with any other buyer.

The "Prudent Buyer Policy" is scheduled to go into effect November 1, 1986. In a letter dated August 1, 1986, Mr Battista requested that by September 15, providers supply information relating to their other buyers - including data regarding payments received from those buyers. The data, according to Mr Battista, is to facilitate the implementation of the new plan.

In his letter to Mr Battista, President Clarisse posed several questions raised by the new policy and questionnaire. The inquires related to:

- o A physician who does not respond to the questionnaire
- o A physician providing services to another buyer but intending to end that relationship;
- o A distinction between payments received for services performed and services a physician has agreed to perform, but not yet performed;
- o The possibility of audits.

In responding, Mr Battista supplied this information:

- o An "across the board" reduction of 20% will be imposed on a physician's profile where a provider fails to respond to the questionnaire;
- o A physician that discontinues a relationship with another buyer prior to November 1, will not be affected by the "Prudent Buyer Policy," however, termination of a relationship with another buyer after November 1, will result in a reduction in the profile for the time period in question;
- o The new plan does not make a distinction between services performed and not performed;
- o The possibility of audits exists in cases where BC/BS is not satisfied with the information submitted by physicians.

To help clarify the concerns of physicians, RIMS has provided copies

"PRUDENT BUYER POLICY" (continued)

of the two letters to all members of the Society. In addition, RIMS has contacted the US Department of Justice, the US Attorney, and the Rhode Island Attorney General's Office in an effort to obtain information relating to the Government's investigation of the BC/BS new policy.

In response to an inquiry by RIMS, Steve Kramer, an attorney with the Anti-Trust Division of the US Department of Justice, confirmed that they are conducting a "preliminary investigation" into the impact the Blue's "Prudent Buyer Policy" will have on the Rhode Island market. Although there is no time frame for completion of this investigation, the Department is aware of the November 1, target date for the new policy's implementation. Mr. Kramer did indicate that Justice is proceeding "as quickly as possible".

RIMS also contacted US Attorney Lincoln C Almond and Rhode Island Assistant Attorney General Steve Mignano. Mr Almond has requested that physician's complaints against BC/BS be channeled through his office at the Federal Building, PO Box 1401, Providence, RI 02901. According to Mr Mignano, the Attorney General's Office has offered assistance to the US Department of Justice in this matter.

RIMS will continue to be in contact with government officials and will keep the Society's members informed as additional developments occur.

SOCIETY PREPARES FOR FALL HEARING ON SURCHARGE

Briefs have been filed concerning the surcharge sought by the Department of Business Regulation (DBR) on all medical malpractice insurance premiums. Previously the Rhode Island Medical Society won a stay of the surcharge and is currently working for a permanent roll-back.

In 1985, the DBR ordered the Joint Underwriting Association (JUA) to assess all new policy holders 50 per cent of their initial premiums and all current policy holders 16 and 2/3 per cent of their renewal premiums as a mandatory contribution to the stabilization reserve fund. When the JUA was established in 1975, all policy holders were required to pay a 33 per cent assessment. The reserve fund acts as a buffer between any deficits incurred by the JUA and a direct assessment of the participating insurance companies.

A hearing addressing the permanent roll-back of the surcharge is expected this fall.

REPORT OF THE AAMSE REVIEW OF RIMS

Action taken by the Council on June 23, 1986, initiated a management survey of the Society's operations by a review team from the American Association of Medical Society Executives (AAMSE). On July 31 through August 2, the team of Bruce E Robinson, President of AAMSE, Timothy B Norbeck, Executive Director of the Connecticut State Medical Society, and Donald P Wilcox, General Counsel of the Texas Medical Association, visited with the Executive Committee and the Society's staff.

Recently, the Society received the AAMSE report documenting their findings. Included in this report are a number of concerns and recommendations ranging from long-range planning to current RIMS activities.

Identified as the number one concern is a lack of written priorities and goals for the Society. Although the report acknowledges the difficulty in determining long range plans (3 - 5 years), suggestions and recommendations are offered to facilitate the Executive Committee and Council in accomplishing this task.

The following are some of the other issues addressed in the report:

- The library and RIMS buildng
- The Journal and Newsletter

- Pursuing a feasibility study of the development of a statewide HMO/IPA structure to increase competition with Blue Cross/Blue Shield and Ocean State
- Exploring an alternative to the JUA
- Restructuring the Rhode Island Medical Political Action Committee.

The review team was pleased with the cooperation of all involved, and expressed the opinion that the Society has high quality people in the executive level. The report is now scheduled for discussion at the next Executive Committee and Council meetings. It is available to any Rhode Island Medical Society member and may be obtained by contacting the Society.

RENEWING THE PUSH FOR MALPRACTICE REFORM

RIMS will participate in at least three new organizations dedicated to relieving the liability crisis. The General Assembly has created a legislative commission to study the rate structure and operations of the Medical Malpractice Joint Underwriting Association of Rhode Island (JUA). A second legislative study commission is charged with addressing the liability problems of municipalities, business, and the professions of Rhode Island.

In addition, RIMS President Peter D T Clarisse joined leaders of the Hospital Association in supporting the formation of a liability reform coalition that would include the RI Federation of Chambers of Commerce, other business groups, and the RI League of Cities and Towns, as well as the health care sector.

The Medical Liability Reform Coalition formed in 1985 is also expected to be active again in pressing the General Assembly for reforms.

RETENTION OF MAMMOGRAPHY X-RAYS

A new Rhode Island State law requires physicians, hospitals, HMOs and other providers to keep mammography x-rays for the life of the patient. Mammography x-rays may, however, be destroyed after fifteen years if the patient has no further contact with the provider during that period."

Frances P Conklin, MD, testified during public hearings on the measure, saying, "Comparison films in mammography are of such importance, it is critical that they be maintained.

COUNCIL APPROVES CRITERIA TO EVALUATE LICENSURE AND DISCIPLINE CANDIDATES

At the August 4 Council Meeting, two sets of criteria for evaluating potential appointees - both physicians and public members - to the newly created Board of Medical Licensure and Discipline were approved.

Under a law passed in the closing days of this past General Assembly session, the current Boards of Medical Review, Medical Examiners, and Osteopathy will be replaced with a single 13 member panel on January 1, 1987. The new board will include four medical doctors, one of whom must be a full time faculty member; two osteopaths; a plaintiff's attorney; a hospital administrator; and four public members with no ties to the medical community. The state health director will serve as chairman.

The Council approved the following criteria for evaluating physicians:

1. Recognized by peers as having exemplary character.
2. Evidence of continued achievement in medicine including but not limited to:
   -scientific publications (local and national)
   -oral presentations at scientific meetings (local and national)
   -academic appointments
   -recognized clinical skills
   -membership in scientific societies
   -board certification and recertification

LICENSURE AND DISCIPLINE (continued)

3. Evidence of leadership qualities in medical and community affairs:
   -officer or committee chairperson of hospital staff
   -officer or committee chairperson of local and/or national society
4. Experience in peer review:
   -recognized by colleagues as a resource in peer review
   -member of peer review committee or organization.

It was endorsed that the first criteria should be absolute. The more standards the candidate meets the higher the recommendation. Suggested recommendations are outstanding, very good, acceptable, and not acceptable.

In addition, the Council endorsed the following criteria for public candidates to the board:

1. Be of unimpeachable moral character and reputation.
2. Display an ability to understand complex issues:
   -formal education
   -life experience
3. Be impartial and not have outstanding personal issues with members of the medical profession which would impair his/her ability to judge.
4. Demonstrate a willingness to make time commitment.
5. Be of good physical and mental health.
6. Demonstrated an interest in the functioning of the medical care system.

It was approved that the first five criteria be essential, and the last desirable.

RIMS has requested that Governor DiPrete review these standards in developing the criteria for evaluating potential members of the Board.

BOOK SALE OFFERED BY RIMS LIBRARY

Now through October 31, RIMS Library is offering older editions of medical textbooks and retrospective medical titles for sale. Grouped by medical subject and/or specialty, these titles are available to RIMS members for 50 cents per copy. Hours for purchases are Monday through Friday, 8:00 am to 4:00 pm, and no appointment is necessary. Proceeds from this sale will be used for library services.

LEUKEMIA SOCIETY LUNCHEON

The Rhode Island Chapter of the Leukemia Society of America is hosting its second annual "Celebrity Waiters Charity Luncheon" on Friday, October 3. Rhode Island Medical Society President Peter D T Clarisse, MD, will be one of 20 waiters hustling tips to benefit the Leukemia Society.

The luncheon will be at the Ocean Cliff in Newport, Rhode Island from 12:00 to 1:30. Tickets are available from the Leukemia Society for $25 per person, and corporate tables are $250. Last year's luncheon raised $6000, and this year's goal is $8000.

RAKATANSKY APPOINTED TO MEDICAL FACULTY COUNCIL

Immediate Past President Herbert Rakatansky, MD, has been appointed to the Medical Faculty Council of the Brown University Program in Medicine. Reviewing the medical program curriculum and providing criteria for staffing and admissions are among the Council's responsibilities. Dr. Rakatansky's appointment runs through June 30, 1989.

FOOD BANK REQUESTS FUNDRAISING ASSISTANCE

The Rhode Island Community Food Bank is seeking a physician to assist in their fundraising efforts for a new warehouse. An aggressive capital campaign is currently underway to raise $1 million and will continue through March. A physician is needed to facilitate the raising of funds within the profession's division.

Any interested doctors should contact the Rhode Island Medical Society for further information.

Rhode Island Medical Journal

September 1986
Volume 69, Number 9

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Rhode Island Medical Journal is owned and published by the Rhode Island Medical Society, 106 Francis Street, Providence, Rhode Island 02903, Ph: 401/331-3207. Single copies $2.00 — Subscriptions $15.00 per year (members of the Rhode Island Medical Society — $5.00 annually). Published articles represent opinions of the authors and do not necessarily reflect the official policy of the Rhode Island Medical Society unless clearly specified. Advertisements do not imply sponsorship or endorsement by the Rhode Island Medical Society. Second class postage paid at Providence, Rhode Island and at additional mailing offices. **ISSN 0363-7913**

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Dr. Caleb Fiske Homestead, Scituate, RI: Dr. Fiske, a charter member of the Rhode Island Medical Society, bequeathed money for the establishment of the Fiske Fund.

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EDITORIAL

Long-Term Care

We have discussed in these columns on several occasions the problem of long-term care of the elderly. The skilled nursing provisions of Medicare were designed and have been implemented to reduce costs — not to care for the elserly sick and disabled. Medicaid reimburses nursing care of the elderly only for the indigent, or for those who have first impoverished themselves by paying for care at a rate of some $35,000 a year. Catastrophic insurance for the elderly is a snare and a delusion. Rhode Island has experimented with it. It has helped mainly young persons with such problems as severe burns or extensive injuries. Recently President Ronald Reagan has made noises about catastrophic coverage. Unless definitions are clarified, however, it will not address the basic problem and will lead to further dissolutionment among the elderly. Fully 50 per cent of all nursing home bills in 1984 were paid directly by patients or their families and 42 per cent by Medicaid for persons who had exhausted their savings.

There are at present 6.5 million persons aged 65 and older needing long-term nursing care. None of this is being paid for by Medicare and that paid for by Medicaid is only for the indigent or pauperized. It is estimated that by the year 2000 9.3 million will need such care, and that the numbers will reach 12.9 million by the year 2020 and 19 million by 2040. This problem will require more than promises of little substance and political sweet-talk.

The elderly population and their families have long become disillusioned with the failed promise of "skilled nursing care." There is some stirring of interest in a genuine solution. But at this time it is hardly more than a dim light on the horizon and private enterprise is responsible for developments to date. The Equitable Life Assurance Society has 150,000 policies in force. A typical policy taken out at age 75 will cost $1,000 a year in premiums and will pay $50-$60 a day, beginning after the first six month's residence in a nursing home. Sales have not been brisk because, in part, many persons naively assume that Medicare (or other insurance) will cover their costs. The chances are one in four that they will use their insurance. Northwestern National Life Insurance Co of Minneapolis will offer a policy called LifeScope which provides comprehensive health insurance with nursing home coverage to retirees who put aside money during their working years to pay the cost of premiums. A limited pilot project is scheduled for next year. It will involve several corporations in the Minneapolis-St. Paul area and many physicians, hospitals, nursing homes, and home-health services. Other experiments will utilize social health maintenance organizations (SHMOs) in a concept developed at Brandeis University which incorporates long-term care. LifeScope will draw on the SHMO concept. The Health Care Financing Administration is showing interest in the SHMO idea, which is designed to keep costs of long-term care manageable. The John Hancock Mutual Life Insurance Co and the Hartford Insurance Group have also shown interest.

The National Center for Health Services Research of the US Public Health Service believe that progress will be slow and will initially be primarily in the private sector. A spokesman for the organization recently commented that "In the short term, the private sector is the way we have to go," and added, "whether there's going to be the political will to do something in the public sector remains unclear."

Seebert J. Goldowsky, MD

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PRESIDENT'S PAGE

More on Long-Term Planning

When I assumed the presidency of the Rhode Island Medical Society, I realized that its financial resources were limited while its needs were great. The Council, in response to this problem, decided that means had to be found to help our members survive in a volatile medical climate.

Rather than attacking the issues piecemeal, as has often been done in the past, RIMS now is committed to solving its organizational growing pains by trying to predict our future needs and planning for them. To help in this effort, we called in a panel of outside experts from the AMA to do a review of the society's management. The team was comprised of Bruce E. Robinson, President of the American Association of Medical Society Executives; Timothy B. Norbeck, Executive Director of the Connecticut State Medical Society (and past Executive Director or RIMS); and Donald P. Wilcox, an attorney with the Texas Medical Association.

The team met with members of the Executive Committee, the Society's staff, and legal and public relations counsel to assess the strengths and weaknesses of the Society. The team was provided with a candid description of what the Society is today, as well as what many of the participants would like it to be five years from now. In turn, the team provided the Society with some solid recommendations on how to get there. A complete report of these findings will be available in the near future.

The following is a preliminary look at the team's findings: *Five-year plan:* It was recommended that, before any action be taken, a five-year plan be developed for the Society by the Council, with the goal of using limited resources in the most efficient way. The plan will set forth the objectives and establish the priorities of the Society.

The Society will survey its members to seek their participation. The Council will utilize this



Peter D. T. Clarisse, MD

information in the development of the five-year plan. The target date to present the plan for approval to the House of Delegates is January.

Finances: The team accurately concluded that the Society is poorly funded for its needs. The serious nature of this situation is readily demonstrated. Last year, the Society assessed each of its members $100 for the malpractice tort reform effort. This additional source of revenue was spent in successfully communicating our message to the media, the public, and the General Assembly. It was used also to hire a lobbyist, whose efforts on behalf of the Society on Capitol Hill were quite effective. Other considerable expenses were not covered by the assessment. Such

expenses incurred in gaining a temporary injunction against the arbitrary surcharge on medical liability insurance premiums ordered by the Department of Business Regulation to bolster the stabilization reserve fund. Also not covered were the costs of an advertisement in the *Providence Journal* to alert the public concerning the impact on their freedom to choose a doctor under Blue Cross' Plan Z.

The team suggested that it was imperative to continue this type of action on behalf of our member physicians, and find the necessary resources to do do.

It was recommended that we take a hard look at our financial base to find ways to make RIMS a financially sound, strong institution. A number of methods were suggested. First, generate support funds other than dues. At present, more than 95 per cent of the Society's revenue is from membership dues with minimal income from our endowments. Second, we must examine how we can increase our endowments, thereby increasing investment income. Third, we must reevaluate our assets with primary focus on our most valuable asset, the building on Francis Street. We must determine the best, most beneficial use of this building. And finally, we must reactivate the Society's brokerage as a way to generate income. This entity presently exists only on paper. Any remaining legal roadblocks to its activation must be overcome.

Membership: The team recommended that we broaden our membership services to meet the needs of all members. Their suggestions ranged from providing travel services to offering dental insurance. We shall investigate these approaches, as well as giving attention to the following:

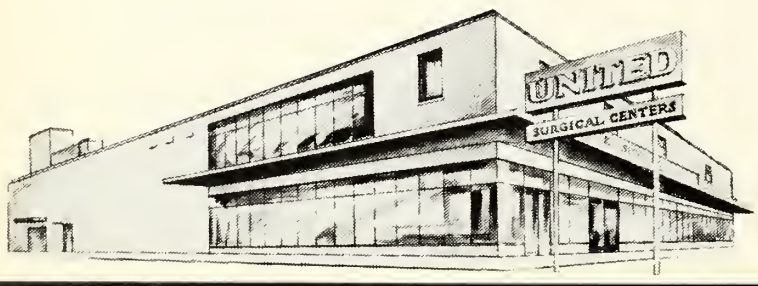
- Alternate forms of medical liability insurance with better rates than are offered by the JUA.
- Communications within the Society, including the adequacy of the *Rhode Island Medical Journal*, and its newsletter.
- The Rhode Island Medial Political Action Committee (RIMPAC) and the need to strengthen it to ensure that our members are heard by legislative bodies fashioning regulations governing our medical practices.

The review ended on a positive note. The review team stated that the Society has come a long way in meeting the challenges presented to today's medical community. They urged that we not retreat from our positive active stance. I shall be counting on your support during the coming months to ensure that we stay on the right road to the future.

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Epidural Analgesia in a Community Hospital

Method Is Safe and Effective When Administered by Trained Competent Persons

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Despite the popularity of prepared childbirth methods, pain during labor continues to be a management problem for both obstetricians and their patients. Stoekel in 1909 first recorded the successful use of regional anesthesia.[1] Continuous caudal epidural anesthesia was introduced in 1942 by Hingson and Edwards[2] and in 1949 Flowers and his colleagues described the continuous lumbar epidural technique.[3]

Our hospital is a 100-bed general community hospital with four board certified obstetricians performing all of the approximately 500 deliveries each year. The issue of the authors providing the epidural obstetrical anesthesia at our institution promoted us to publish our results.

Eighteen hundred and twelve patients were given peridural analgesia from 1976 to 1985. Both lumbar epidural and caudal techniques were used. This review considers the safety, availability, and effectiveness of peridural analgesia. Five-tenths per cent or 0.25 per cent bupivicaine hydrochloride without epinephrine was the anesthetic of choice in the majority of cases, with mepivicaine hydrochloride used occasionally in the earlier years.

During the past two years, the use of a continuous infusion pump dispensing 15-20 milligrams of bupivicaine per hour was used on occasion for more constant relief of pain in patients facing a long first stage of labor.

The authors are in the private practice of obstetrics and gynecology in Wakefield, Rhode Island, and associated with South County Hospital.

Results

Hypotension is the most commonly reported side effect of regional analgesia with the incidence varying to a high of nine per cent, depending upon the definition of the term.[4] Our incidence was consistently below this figure, as we treated incipient hypotension with intravenous infusions for volume expansion, left lateral position with leg elevation, and nasal oxygen. This resulted in the rapid correction of the hypotension, except for rare cases requiring in addition 25 to 50 mg of ephedrine. Transient hypotension does not in itself result in increased maternal or neonatal morbidity.[5]

Dural puncture has occurred rarely in our cases, which compares favorably with other reports. The annoyance of severe post-delivery headache is acceptable considering its rarity and other advantages of epidural analgesia. Hypertension has not been noted in our series. However, we have not used epinephrine with our bupivicaine injections. The combination has been reported as the probable cause of acute hypertension during regional analgesia.[6]

Neurologic complications have been reported as a result of the accidental injection of agents into the subarachnoid space.[7] This has been recorded specifically with the use of chloroprocaine in a large single bolus injection. Cardiac arrest has been reported during the injection of 0.75 per cent bupivicaine intravenously. However, these reports have not been confirmed by other investigators. For our needs, lower concentrations of bupivicaine have been satisfactory.

The possible effects of epidural techniques on labor have been studied extensively. Opinions

have varied. Epidural analgesia appears to lengthen total labor if begun too soon.[9] Small intermittent doses of bupivicaine produced no decrease in uterine activity once active labor had begun.[10] We have frequently noted an increase in effective labor once analgesia has started. The question of prolongation of the second stage of labor was addressed in 1983 by Phillips et al.[11] They state unequivocally that epidural analgesia does not prolong the second stage, that the incidence of operative delivery is not increased, and that the lessening of pain is obvious.

Fetal effects of epidural analgesia appear to be transient and are proportionate to the volume and concentration of the agent administered to the mother. The authors presently are using bupivicaine because of its maternal binding properties with consequent lower fetal concentration. If hypotension is brief, there is no demonstrable effect on newborn umbilical cord blood gasses and Apgar scores.[12] Fetal monitor pulse-rate deceleration occurs occasionally with intermittent, continuous epidural technique. Occurrence is extremely rare with a continuous infusion method. Post-delivery blood gas determinations, Apgar scores, and neurologic evaluations show no residual effects with transient late and variable monitor decelerations.[13]

Availability

The authors provide obstetrical care, including routine obstetrical analgesia, for the laboring patients on our unit. Each of us received anesthesia training during his residency program, allowing us to offer peridural analgesia to our patients. Timely use of the epidural technique is requisite to its popularity. Since the authors are readily available to our labor patients, we can offer this method quickly when it is requested and indicated. Attempts to encourage a new obstetrician to practice in our community have been thwarted by a lack of obstetrical anesthesia training in many residency programs.

When anesthesia is required for either complicated vaginal or Cesarean delivery, the presence of an anesthesiologist is assured. Our anesthesiologists are available for all complicated deliveries, but they are not required to be in attendance with normal labor and delivery. This arrangement has been mutually agreed upon by the departments of anesthesia and obstetrics. The qualifications of those performing obstetrical analgesia are specified, and the results are monitored by both departments.

Effectiveness

The incidence of failure to insert an epidural catheter approaches zero. Unilateral analgesia is not uncommon and is secondary to insertion of the catheter into the peridural space beyond two centimeters. Usually this is correctable with partial catheter withdrawal or lateral positioning of patients at the time of injection plus increasing the volume administered. Epidural analgesia gives adequate pain relief through all stages of labor except in instances when general anesthesia is required.

Discussion

Pain relief during labor continues to be a primary responsibility for obstetricians. Despite the constant availability of obstetric anesthesiologists in some centers, there is still a continuing need for safe and convenient analgesia for most labor patients. Peridural analgesia by continuous infusion or intermittent dose provides satisfactory pain relief for the majority of labor patients. Prepared childbirth techniques and narcotic analgesics continue to provide choices for our patients, but often the unpredictable necessitates another method of pain relief. Paracervical block is useful only in the first stage of labor. Many reports of fetal bradycardia and fetal acidosis attributable to high fetal blood levels restrict its usage.[14] Saddle block is restricted essentially to relief in the second stage of labor. The incidence of five per cent post-delivery headache also limits this choice.

Pudendal block is similarly limited to pain relief late in labor since its effects are confined to the perineum and lower vagina. We frequently supplement epidural analgesia with local infiltration into the perineal tissues if repair of an episiotomy or laceration is necessary. The limited dosage we are using for epidural effect is not intended to give total anesthesia. This fact is discussed with our patients prior to the use of this technique.

Conclusion

Epidural analgesia is safe and effective for patients in labor when administered by trained, competent personnel.[15] These features are confirmed by our review. Availability in some communities continues to be a problem, which we feel can be addressed reasonably by obstetricians working in harmony with their anesthesiology colleagues.

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The Art of "Doing Nothing"

David F. Wehlage, MD

> What is the most painful and devastating question that can be asked about modern medical practice? It is not whether most doctors are up to date in their knowledge or in their techniques, but whether too many of them know more about disease than about the person in whom the disease exists.[1]

Each moment with another person can be an opportunity for discovery and growth or for the erosion of identity and the destruction of one's sense of well-being. People's sense of psychological and physical well-being is linked to the caliber of their communications and relationships with others. Ineffective communications and relating cause interpersonal friction, especially between physicians and patients. Since there is a strong desire in most people for effective communication and relating, why is it so difficult to establish? One of the primary reasons is that people, especially physicians, typically inject communication and attitude barriers into their ways of relating. Years of habit and tradition promote tendencies in physicians which make it difficult for them to understand the ineffectiveness of their communications and for them to change. This paper will dissect the traditional mode of helping others by the "doing something" approach. It will show the ineffective aspects of "taking care of" others and how most physicians' ways of relating are so frequently counterproductive of their intentions. It will provide the specific attitudes and mechanics of an alternative "do-nothing" approach.

Helping others appears to be an inherent motivation for most people. The desire to assist and the activity of taking care of someone is rooted in the perpetuating evolutionary imperative of reproduction, parenting, and raising children. Having been "taken care of" by parents gives most people a rudimentary understanding of the process of "taking care of." The sense of helping others — altruism — results from this natural parental urge as well as the sympathetic sensitivity for other's pain resulting from one's own experience with pain and misfortune. Everyone has suffered in some manner at some time which makes one somewhat aware of others' pain and frustration. "Helping others" seems so instinctive that most people presuppose the mechanics and techniques of helping are common sense. The rudimentary common sense approach of helping usually involves a sense of rescue and urgency, ie, something needs to be done immediately. The process of effecting urgent rescue pervades most helping efforts, including those of physicians.

The sense of rescue is based upon the partial truth that a person is helpless and needy at times of crisis, but it denies the ability of most people to cope until optional ways of problem-solving occur. The sense of urgency leads to presumptuous intrusions and interventions based on the rescuer's egocentric view that he or she knows what is best. Altruistic interventions, solutions, and advice are frequently set in motion without the permission of the person in crisis. In addition to rescuing people, the medical profession has a tradition of "doing good." However, there has been a growth in the number of people "doing good," particularly in the realm of social service, ie, social workers, agency volunteers, politicians, religious missionaries, and various ancillary medical personnel. The proliferation of the helping professions has spawned many untrained, immature, and inexperienced helpers, including physicians, who rely on their sympathetic, common-sense approach as the guide for their help-

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ing behaviors and attitudes. The "doing good — doing something" type of helping is fueled by the belief that people are helpless and innocent victims of uncontrollable forces and need to be rescued. Since modern physicians leave medical school with a knowledge of a vast array of sophisticated medications and technological devices, they are able to deliver a better medical product (rescue) than has ever been possible. However, there is a public debate about the quality of care given by physicians who generally help by the "common sense — do something" method. The reasons given for this debate range from the charges that people are not being given proper medical care to complaints that physicians fail to react to patients as individuals.[2-4] Patients complain that physicians are too busy, too specialized, and too abrupt to listen. Through all of this, the glaring problem appears to be not what physicians do, but how they do it.[5]

Besides the intrusive, altruistic "doing good" mentality, there is another attitudinal stance in medical care which has led to conflict between patients and physicians. People go to physicians because they feel uncomfortable or unusual. They also go because they feel sick, are coughing, feverish, and in pain, not because they have "pneumonia." It is the physician who labels one as having the disease such as pneumonia to explain how one feels.[6] Diseases are entities in which structural change takes place and for which unique causes can be found. When one feels ill (unable to do the usual), one assumes there is a structural, physical aberration which can be discovered, labeled, and treated. Physicians have come to expect the same thing; and, if no disease can be found, physicians have behaved as if there is nothing to justify a visit. Although the search for definitions (diagnosis) has always been essential in scientific medicine, anyone who has ever felt ill knows that only hearing you do or do not have a disease forms an incomplete picture of illness.[7] Since the development of cures is contingent upon knowing the what and why of disease, it is obvious cure will be directed only against the scientifically-proved objective manifestations defined as disease. But in cases such as chronic illness, eg, emphysema, cancer, arthritis, or where one feels bad with no definable disease, eg, emotional disturbances, curing or "doing something" procedures are deficient. If they do help, they represent only a part of fully returning the patient to health.

What has happened within the last generation is that the hope of curing disease has become more of a possibility. Therefore, illness and disease have come to be separated. If there appears to be a difference between illness and disease, is there also a difference between healing and curing? Curing may be defined as returning a diseased part to functional integrity, ie, killing bacteria, removing an inflammed appendix, or replacing a damaged heart valve. Healing is returning a person to a state of well-being and fitness to perform one's usual activities. A stroke patient may limp for the remainder of his life, but may feel healthy. Conversely, one may recover from the limp but feel frightened of another stroke and thus remain ill. The process of healing involves the function of relieving suffering whether it is found with or without disease.[38]

Physicians have been and remain pivotal in these emerging conflicts. The unquestioned sense of responsibility which they have assumed for people has led to unbridled efforts to save people and to coerce them with technological information. Besides possessing a legal license to diagnose and recommend treatment, physicians have been inculcated with and respected as possessing extraordinary power and expected always to have the patient's best interests in mind by promoting healing. Though well-intentioned, physicians have naively responded to the sick with the unholy trinity of activity, authority, and magic.[8-10] Aesculapian authority is what Paterson called the

Table 1

JUDGING
1. Criticizing
   "You are acting foolishly"
2. Analyzing
   "You are just trying to get attention"
3. Evaluative praising
   "You are a wonderful person"

GIVING SOLUTIONS
1. Commanding
   "You have to . . ."
2. Threatening
   "If you don't, then . . ."
3. Moralizing
   "You should . . ."
4. Advising
   "I think it would be best to . . .'
5. Lecturing
   "Do you realize that . . ."

AVOIDING OTHERS' CONCERNS
1. Interrogating
   "Why did you do that?"
2. Reassurance
   "Don't worry"
3. Diverting
   "We don't talk about that"

Table 2

1. Am I satisfied with my financial status over the last year?
2. Am I satisfied with my current occupational status?
3. Am I satisfied with my current educational level?
4. Am I satisfied with the importance of religion in my life?
5. Am I satisfied with my current living situation?
6. Am I satisfied I can turn to my family for help when something is troubling me?
7. Am I satisfied with the way my family talks things over with me and shares problems with me?
8. Am I satisfied with the way my family expresses affection and responds to my emotions such as anger, sadness, and love?
9. Am I satisfied with the frequency and quality of my sexual activity?
10. Am I satisfied with the way my family and I share time together?
11. Am I satisfied with the way I spend my leisure time?
12. Am I satisfied with how I use alcohol?
13. Am I satisfied with how I use non-prescription drugs?
14. Am I satisfied with my ability to stand up for my thoughts and ideas with other people?
15. Am I satisfied with my ability to let other people know my feelings and emotions?
16. Am I satisfied with my ability to make friends?

composite traditional attitude of physicians. This comprises sapiential, moral, and charismatic authority. Sapiential authority is the right to be heard and obeyed because of special knowledge. To maintain this authority, physicians must know or appear to know more about medical matters than their patients. Moral authority is derived from physicians appearing to do what is right and good for their patients. It allows physicians to control and direct without having to justify themselves. Charismatic authority gives physicians a right to pontificate about almost anything. It is based upon an abstract faith and believe in the physician when patients are faced with serious and mysterious issues like birth and death. The use of Aesculapian authority has remained stable for centuries and has guided physicians and patients in how to act with each other.[6]

Parsons has called our attention to the fact that both the patient and physician have learned clear-cut roles and expectations of one another.[12] A "good" patient with an acute disease state is relieved of social responsibility so that he or she may do whatever the physician dictates. The patient is expected to withdraw from work, family responsibilities, and pleasures in order to seek, comply with, and respond to appropriate medical intervention. The physician is expected to take charge of the patient's disease, give explicit directions, report on the patient's progress, and communicate with the family. The patient is rendered passive-dependent and is seen as not being responsible for becoming sick. Chronic disease on the other hand imposes a different series of roles and expectations. The chronically sick patient is expected to master the disease and illness as much as possible while continuing to function at some level at home and work. Out of frustration, physicians usually come to reject being totally responsible for the undiagnosable or incurable and place more burden on the chronically ill patient to avoid physician contact unless there is an "emergency." The confusing and conflicting roles and expectations of the emergency medical rescue model versus the healing model produces many treatment problems and unsatisfactory outcomes.

This physician-dominated type of relationship was described by Szasz and Hollander. However, they delineated three types of physician-patient relationships to clarify the concept that helping patients is more complicated than the traditional, authoritarian, common-sense approach.[13]

Activity-passivity: In activity-passivity relationships, professionals are active and patients are passive. Treatment takes place regardless of the patient's contribution or active participation. This mode operates more appropriately for the treatment of medical emergencies, especially if the patient is comatose.

Guidance-cooperation: In guidance-cooperation relationships, patients are competent and express feelings of being willing to cooperate to get the help they sense they need. Although patients are not viewed as totally helpless by physicians in this mode, the patients are expected to obey, follow rules, and comply.

Mutual participation: In mutual participation relationships, patients and physicians are equal, and each is concerned about the other. There is a collaboration between patient and physician relative to knowledge, concern, and the assumption of responsibility for one's well-being.

The activity-passivity mode requires physicians to do what is medically necessary without emphatically wondering what patients might feel. It gratifies a physician's need for superiority. In the guidance-cooperation mode, the physician sees the patient as a child who needs to be taught and molded into what the physician feels is right and proper. It requires that the physician be convinced that he or she is right about what is best

for the patient. Szasz and Hollander state that the mutual participation mode or the covenant model "has elements often associated with the notions of friendship and partnership."[14] The physician may be said to help the patient help himself. The physician's gratification cannot stem from power or from control over someone else. With mutual participation, the physician does not profess to know everything and certainly does not demand that a patient agree. In fact, the physician admits that patients know more about themselves than anyone else and more about what they want and what is best.[15, 16]

A mutually-concluded agreement about what is best for the patient and what "health" means is a process difficult for physicians to incorporate into their role behavior.[17, 18] Physicians tend to emphasize a goal-directed approach to clinical problems, as opposed to a process-directed approach. They are oriented to pinpointing pathology rather than to being interested in and available to listening to how a person becomes sick and experiences and adapts to sickness. This unfortunately involves focusing on "what is wrong" rather than "how did this come about." Physicians have been trained to expect the worst of any symptom and "do everything" to diagnose and treat it without regard for the destructive aspects of doing too much. Engel has emphasized the biophyschosocial model as a means of integrating the goal-directed and process-directed approaches.[19, 20] A process-oriented physician is not so interested in isolating a single cause as in managing the outcome (a reasonable outcome, not an optimal one). He or she may likely sacrifice knowledge, eg, a hazardous diagnostic procedure, when adequate management can be provided without it. *A process-mutual participation approach allows for inaction and focusing on subjective experience and motives rather than on disease and diagnosis.* This recognizes that the context of the patient's complaint and the treatment process are as important as the content. The search for organic causes is necessary for diagnosis, but is not sufficient for the management and the relief of suffering.[38] Although it has come to be viewed as an applied technology within the biomedical framework, medicine should still be viewed as a social practice. The public has not lost the awareness that the physician-patient relationship is still the vital aspect of therapeutic intervention.

Besides the altruistic and dogmatic attitudes, physicians need to recognize that certain ways of verbalizing carry a high risk of putting a damper on conversation, being harmful to a relationship, and triggering feelings of inadequacy, anger, or dependency in the patient. As a result of various attitudes and communication roadblocks, the other person may become resistant or rebellious or withdrawn or argumentative or despondent. The recipients of these barriers to communication and relating may also become very submissive, but they will almost always feel diminished in their self-worth and motivation. The likelihood that the other person will feel adequate, competent, and better about himself is minimal. Gordon stated that rescuing by acting superior and all-giving "the (immature) 'professional change agents' have proven that unacceptance (depreciation) closes people up, makes them feel defensive, produces discomfort, and makes them afraid to talk."[21]

Communication barriers are responses whose impact on relationships is frequently negative. If physicians accept the responsibility of helping raise people's feelings of self-worth and self-confidence, then anything which promotes a decreased sense of personal well-being should be modified. Similarly, if certain types of communication lead to non-compliance, resistance, anger, and interpersonal disgust, would not a physician be wise to change the way he relates and communicates? The communication barriers are more likely to be destructive when people are interacting under stress or strong personal need. Obviously, most physician-patient encounters take place in an atmosphere of strong personal concern.

Everyone uses communication roadblocks sometimes and especially when someone feels under pressure to respond or "do something" for a person in need. Their occasional usage will rarely harm a relationship; but, when employed frequently, there is a high probability that they will do considerable harm. What are the specific attitudes and verbalizations which are apt to hinder conversation and the development of a positive relationship? The undesirable responses include *judgment, giving solutions, and avoidance of others' concerns.*[21, 22](Table 1)

At first glance, some of these responses seem quite innocent. Praise, reassurance, interrogating, and well-intentioned advice are often thought of as positive factors in interpersonal relations between physicians and patients. Why then do professional therapists think of these eleven types of responses as potentially damaging to communication? All of these responses are inherently depreciating, especially, commanding, advising, and criticizing. They imply a superiority and ar-

rogance which makes people feel inadequate, rejected, and humiliated. Such responses may stifle any further communication from patients because they are made to feel inferior. They are more likely to block interaction, thwart the other person's problem-solving ability, and increase the emotional distance between physician and patient. But what is really wrong with advice and sending solutions? One problem with advice is that the adviser seldom understands the full implications of the problem. When people share their concerns, they often display only the "tip of the iceberg." The advisor is unaware of the complexities, feelings, and the many other factors which lie hidden beneath the surface. Secondly, advice is often a basic insult to the intelligence of the other person. It implies a lack of confidence in the capacity of the person with the problem to understand and cope with his or her own difficulties.

Borsky described some clinical indications which should definitely alert a physician to the fact that a "do something" approach is not likely to succeed.[26,27] First, when patients exaggerate somatic symptoms; second, when a diagnosis seems impossible, vague, complicated, or unnecessary; third, when patients are angry or dissatisfied with medical care; and fourth, when there has been no change in the clinical status in spite of several medical-surgical interventions. These patients frustrate physicians' need to decide, "what can I do or tell this person?" Besides the clinical scenarios, there is a wide range of people who cannot respond to authoritarian attitudes. Most everyone will react negatively to a pompous, abrupt, abrasive and non-listening physician, but even more subtle authoritarian responses elict a negative reaction in many people. All people have mixed feelings about authority because of their early childhood experiences with authority figures. Many people come to mistrust authority, many are angry at anyone telling them what to do, and many feel defensively superior themselves, which leads to rejecting even a benevolent authoritarian response. All of these people become sick and need to visit and communicate with a physician; so a non-authoritarian approach is essential for their treatment and relief. Similarly, most physicians react with aversion to clinging, demanding, and dependent patients, but usually do not understand how they might be facilitating demanding dependence and clinging obedience in patients. *Through their intimidating directive approach or their oversolicitons "do everything" attitude, physicians stymie patients from becoming more self-reliant and more autonomous.*

Two other large groups of patients who frustrate physicians trying to "do something" are the chronically sick and the "worried well." Efforts and responses oriented to curing the incurable and reassuring the persistently worried well will not likely lead to satisfying outcomes. Physicians frequently have no clear-cut, definitive idea of what to do or say which will be helpful, even to patients with diagnosed medical disease. Physicians are pressured into the "do something" approach which may even include fabricated answers, flippant advice, or inappropriate medical interventions. They may not know that there is a participatory therapeutic alternative. A variety of factors are present in today's society contributing to the demand for mutual participation in medical matters.

It is only in recent years in some advanced countries that many people have reached adulthood without being exposed to life-threatening illness and death in their homes. Similarly, few people have suffered serious illness themselves in their early life. Therefore, people have not learned the social rules of being sick and how to relate to the physician as the God-like savior. The increased use of the media for health information has made people more knowledgeable and inquisitive. This inquisitiveness and the spread of primary prevention programs which motivate people to be accountable for their own health have led to patients becoming more willing to question, discuss, and even argue with physicians. Obviously, there is a growing number of people who are unresponsive to advice or pure medical-surgical modalities, ie, persons such as the chronically ill, the worried-well, the enlightened, and the non-compliant. Beyond these reasons is the alarm over the rising costs of health care. This has given the "consumer" patient more of a right to determine how, when, and where medical care is offered. The leverage patients have gained legally through malpractice and informed consent litigation has strained the authoritarian aspects of the physician-patient relationship. As society becomes more supportive of personal autonomy, human rights, and individual assertiveness, the power of the patient increases and the inequality in the relationship with the physician less pronounced.

Physicians who are "do-gooders" or "doctorly" authoritarian figures pay a high price. Being omnipotently "on fire" can lead easily to occupational "burnout." They can become discouraged, bewildered, and angry when confronted with the

vast array of unanswerable questions, signs, symptoms, psychosocial issues, and human mysteries which patients present. For the physician to assume the major responsibility for solving all of these problems and to try to "do everything" leads to results which are predictably unsatisfactory. The goal-directed, diagnostic, authoritarian approach which serves so well with problems such as hemorrhage or infection usually fails in the extended biopsychosocial context. Physicians become dismayed when patients with abdominal pain, fatigue, headache, or obesity do not respond to the vigorous use of diagnostic procedures and directive medical treatment. Such results have often lead physicians to question their therapeutic abilities.

When a physician is able to feel and communicate genuine acceptance of the patient, he possesses a capacity for being a meaningful helping agent.[23, 25] The physician's acceptance of the patient is the important factor in fostering a relationship in which the patient can grow, develop, make changes, solve problems, become healthy, and be more creative in living. When a patient feels truly accepted, the times a physician needs to advise, direct, and teach become less depreciating. Under these circumstances, a patient will more readily accept some authoritarian attitudes from the physician, knowing the physician does not intend to make one feel inferior, stupid, or inadequate. Since physicians often choose medicine as a profession because of their self-inflating need to "do something" for people, the necessity for a collaborative "do nothing" approach frequently only becomes evident as physicians recognize patients are dissatisfied or not "cured." Patients expect and deserve something more from physicians than just technical expertise about biological issues. Medical care and evaluation imply not only physical examination and laboratory results, but also knowing the story of a patient's lifestyle, family background, and complaints. Physicians frequently do not know the full story, since it is acquired longitudinally by a series of visits rather than cross-sectionally in one visit. The art of "doing nothing" is the way to offer the understanding and therapeutic relationship most patients desire from physicians.

The art of "doing nothing" is learning to help by *not* doing or advising. It is the ability of the physician to use one's personality and physical presence as the therapeutic agent — not a scalpel, a medication, or a parental command. It is the wisdom to recognize the ultimate therapeutic value and benefit of gathering a history ("getting the full story") and recognizing that *evaluation is the treatment.* It is the physician's consummate ability of "being there" for the patient without feeling uneasy, helpless, guilty, or inadequate. *This art can be and should even be a part of the physician-patient encounter when there is a definitive medical treatment.*

While it may be redundant to reemphasize it, physicians must remember that they cannot dichotomize illness into mutually exclusive functional and organic categories. Rather, they deal with individuals who concurrently suffer from emotional and physical disorders. These conditions interrelate, so that worsening of the emotional aspects has a direct effect on the physical sickness and vice versa. The art of "doing nothing" is the ability to help patients feel better about themselves as persons. The following steps are involved with helping by "doing nothing."

Avoid Asking, "What Can I Do?"

All physicians are aware of the inner attitude and imperative which says, "What can I do or say?" They usually become more occupied with an answer than focusing on "what is the patient telling me about his or her problem?" and "what else do I need to know to understand fully what or if anything needs to be done?" Any time the patient's complaint is complicated or vague and any time the physician does not know definitely what to do or say, he or she is obliged to think, "I must find out more about this." Clear information about symptoms is necessary for a medical diagnosis if there is one, but the physician concerned about a positive outcome also must know the patient's assets and liabilities (eg, reliability) as well as the patient's potential to solve problems. This does not require the inordinate amount of time physicians suppose. The process of arranging time to clarify the patient's complaints or find out what the patient really wants is the beginning of the "do nothing" approach. It is offering an opportunity for the patient to inform (teach) the physician, which in itself is therapeutic. It means allowing the patient to leave the office without a diagnosis, prescription, laboratory slip, referral, or advice. This approach is based on the following suppositions:

(1) Do not presuppose that people want something done.
(2) Do not presuppose people who are unwilling to help themselves can be helped.
(3) Do not do something for people they can do themselves.

(4) Do not presuppose people want to give up their complaints.
(5) Do not presuppose there is something to offer.
(6) Everything which can benefit someone can also cause harm.
(7) Every person is capable and finds it helpful to clarify or elaborate about what is really troubling him.
(8) A physician is more willing to listen if he or she is aware of what one does not know rather than what one does know.
(9) It is useless for physicians to treat someone who wants attention, not intervention.
(10) Physicians must believe and understand that they can be of value to people without always knowing in what way.

Get the Patient's Story

Paying attention and getting the full story does not have to be accomplished immediately and, in fact, cannot be obtained in one brief session; but when done appropriately, it brings relief from the helplessness which patients experience. No definitive answers or medical procedures are necessary to achieve relief or encouragement, since the patient feels respected, heard, and understood. A physician must understand that an investigating stance toward a patient is more helpful than an interrogating one. In communicating a state of discomfort (illness), the patient brings to the physician a set of expectations which are based on what the patient has known in the past about people who help; this accounts for the beneficial placebo effect.[28] The process of eliciting a personal history as people would do in developing friendships, is the cornerstone of the art of "doing nothing." To provide comfort to an ill patient, the physician should know the patient, the family background, culture, religion, social status, occupation, present and future plans, habits, and, it is hoped, the patient's value system. The patient's ideas about the cause of sickness and its "cure" determines what type of treatment will be permitted, how compliant a patient will be, how faithful and loyal the patient will be to the physician, and, most importantly, how one will structure one's life to cope with a sickness or illness.[29, 30]

How to investigate the patient's life in a careful, encouraging, helpful manner is the skill needed by the physician. A suggested screening questionnaire to introduce the patient and physician into personal areas of clinical interest is provided in Table 2. The "do nothing" method is therapeutic because it is a collaborative process of helping the patient help himself or herself and finding out what he or she wants, not what the physician or other people want for the patient. To elucidate the patient's attitude about helping and doing for himself, the following questions must be asked during the initial session:

(1) What makes your condition better?
(2) What makes your condition worse?
(3) What do you feel caused your condition?
(4) How would you manage if your problem did not improve?[31]

The physician's interest in the answers to these questions is a vote of confidence for the patient that his or her knowledge and concern about the condition is valued. Also, physicians need not feel devalued by the fact that they are not the only source of helpful information or suggestions, since patients read and consult many non-medical sources for relief and comfort. Physicians need not expect themselves to be *the* solution or part of the solution to every problem presented by patients. Encouraging the use of self-help programs and the patient's self-generated ideas about what to do is a major part of the "do nothing" approach.

Maximize the Physician's Presence

The expectation of being helped is powerful, and the physician's presence makes patients feel safe. Without any action, guarantee, or promise from the physician, most patients believe the presence and attention of the physician will lead to some form of relief. When the physician listens attentively, encourages, and supports the necessity to face painful experiences and the distress of frustration, the patient feels a bond of partnership. With this occurring, patients become more persuadable when physicians point out or suggest that better solutions exist for old or new problems.

A calm, unhurried, attentive attitude in the midst of the patient's fear and turmoil is essential. The physician's personality ("bedside manner" and charisma) is a major factor in the ability to listen to a patient. Physician-patient interactions should be conducted in a private comfortable setting using facilitating interview techniques, eg, "you mentioned your (father, husband, heart, sadness, or other), and I would like to know more about that," or "what else would you like to tell me about yourself?" What a person wants most from a listener is a sense of psychological presence. He or she wants the listener to really be

there. When a physician works in a private environmental setting, has comfortable eye contact, appropriate body motion, and attentive posture, the patient can feel psychological presence.

Saying nothing and listening can communicate acceptance. Silence on the part of the physician gives the patient time to think about what to say and thus enables one to go deeper into the problem. Silence also allows the patient to proceed at his or her own pace. Silence often serves as a gentle nudge to go further into a conversation. Silence on the part of patients often makes physicians ill at ease, and they compulsively begin to talk and ask questions, as opposed to just waiting for the patient to continue.[39] Physicians who cannot tolerate silence focus attention on their own inner disquiet, rather than on the patient. One of the primary tasks of a listener is to stay out of the other's way, so that the listener can discover how the speaker views the situation.[22]

Silence or "passive listening" is a potent, nonverbal message and can be used effectively to make a person feel genuinely accepted. However, most people realize that one cannot remain silent very long in a human interaction. Talk can heal and promote constructive change. However, it must be the right kind of talk. Listening does not involve a total silence, but verbalizations must be oriented to helping people tell their stories more fully, not preaching, correcting, or advising. It is well known that people do a better job of problem solving when they can talk it out as opposed to merely thinking about it or having someone else tell them.

Besides using proper facilitative interviewing techniques,[32] the principal activity of a physician in a "do nothing" session is offering support or encouragement. The four basic characteristics of support are:

Positive attitude: This involves communicating verbally and non-verbally that "I am glad to see you." This should not be excessive cheerfulness, exuberance, or frivolity, but a quiet sense of contentment in being with the patient.

Agreement: This involves finding issues and statements with which to agree as opposed to disagreeing and debating with patients. A patient should never be scolded or vigorously corrected. Support involves focusing on what is positive ("that seems like a good point") and helping patients find good things about themselves. It involves suggesting rather than dictatorially correcting ("have you considered?" or "has it occurred to you?"). The physician intends to show respect for the patient as a competent problem solver and to discuss openly the appropriateness of medical recommendations. *The physician must accept a responsibility for persuading patients about health behaviors rather than commanding obedience.*[33, 34]

Understanding: This involves "active listening" and encouraging the patient to elaborate on issues.[21] Wanting to know about the patient's life beyond the immediate problem indicates a desire to understand. Understanding requires empathy. When a physician listens empathetically, he or she is trying to sense the patient's way of experiencing and looking at the world. Encouraging and allowing the expression of emotion is a fundamental of a "do nothing" session.

Collaboration: This involves the recognition that the patients are the teachers.[35-37] They must be given permission to teach the physician about their problems, their lives, and their ideas about treatment. Collaboration is reinforced by asking patients ("would you consider . . . ?") if they would be willing to have a blood test or other procedure. Physicians seldom ask patients' permission to recommend and arrange diagnostic and treatment procedures. Support is as much what a physician does not do as what he or she does. Support is not the same as reassurance. Physicians should not reassure patients unless the patient specifically asks, "Doctor, will I be OK?" Global reassuring statements such as "everything is OK" or "you are just fine" are seldom helpful, and patients usually feel casually dismissed when they are treated this way.

Invite Patients to Return for Another Visit

The principal assistance physicians have to offer most patients is the opportunity to return for another visit. "There is a lot you have told me that I would like to hear more about. Would you like to see me again to explain it more fully?" This statement implies that the patient has been heard, cared about as an individual, and gained understanding. Seldom do patients refuse to return for a scheduled appointment if they know the specified amount of time available to talk. Offering repeat sessions as short as twenty minutes may be the most beneficial thing physicians can "do" for their patients. Patients usually guide the physician as to the number of sessions needed for their improvement and their requests to lengthen the interval between visits.

Emphasize the Benefit of Time

Patients are helped when the physician says, "My experience with this problem is that it will improve with time and with what you have already been doing, but I would like to see you again if you wish." Suggestions discussed may later be turned into action by patients. The patient usually has been living with the problem for some time and will survive for a while longer. "Doing nothing" may be interpreted negatively by some patients as the physician withholding "curative" services. However, a majority of patients react more negatively to "doing too much too soon." They feel as if physicians have not listened, possibly made a mistake through hasty judgment, or just tried to get rid of them. When patients ask questions such as "what do I do?" or "what are you going to do?" answering them with one of the following direct, but honest responses will suffice: "I am not sure I know, but I would"; "I do not know what to suggest, but I would"; "I do not think that is something I can help you with, but I would"; "That is something you may have to answer for yourself, but I would"; or "I would like to see you again soon to find out more fully what the nature of your problem is and keep in contact with you to see if anything else might be necessary."

Case Presentation

A 19-year-old woman, seen initially for birth control evaluation, was recognized as having recurrent yeast vaginitis. The question of diabetes mellitus arose and was answered when a blood sugar test was revealed as 280 mg per cent. The assigned family practice resident called the patient without any introductory discussion and told her that she must be hospitalized immediately for instructions about using insulin. The patient seemed compliant and passively dependent to this sudden and commanding advice.

The woman was living with a boyfriend, whom she supported by working as a waitress. She had left home many times as an adolescent because of conflicts with her mother and brother. She had dropped out of school at the age of 17. She had no memory of her father, who deserted the family when she was two.

Upon admission to the hospital, she became belligerent, hostile, and verbally abusive to the resident physician. She stated she did not want to know about diet or insulin, but she wanted another medical opinion. An internist evaluated her and authoritatively told her that she had diabetes and required insulin, and ordered the nurse to administer it. Verbal abuse toward the resident continued with statements such as "*your* insulin has made me feel no better, and I do not know why I am forced to stay in the hospital." The resident was angry and hurt, but in a controlled way told her that she could have another physician if she wished. She did not answer and quietly accepted the plans for discharge and follow-up visits.

She kept one outpatient visit three weeks after discharge. She was sullen and non-compliant. It was unclear what she had been doing with her diabetic regimen. She did mention in that visit, "That goddamn father of mine only gave me one thing in my life." She had discovered after discharge that her father was diabetic. The resident talked to the author, and the following issues were elucidated.

The patient was involved with the resident in a "parent-child" relationship and resented and mistrusted any type of authority. The grief reaction precipitated by the loss of body integrity (an adolescent developmental lifestage concern — "I would never tell anyone I have diabetes") activated all of the previous anger-provoking losses in the woman's life — father's abandonment, mother's rejection, and a girlfriend's death. I recommended that the resident figure out a way to try to establish a non-authoritarian approach. This involved inviting the patient to some sessions to talk about issues in her life other than diabetes. I encouraged a "do nothing" approach and urged the resident to clarify what the patient was really concerned about (no one had ever asked her about any of her concerns) and try to become her trusting "friend" before getting too involved with specific medical management. Also, the resident was urged not to reject his patient by pushing her to another physician.

The resident should have "done less" initially by not assuming total responsibility for the diabetes and trying to effect an immediate rescue. Definitive medical recommendations should have been suspended until the patient was ready to enter into a collaborative relationship. Retreating to a less authoritarian stance was more difficult and took longer than it would have in the beginning.

The patient responded well to a "do nothing" approach and within three months had perfectly controlled diabetes. She never missed any of her biweekly, twenty-minute appointments. Her diabetes was seldom discussed, and she mentioned on one occasion, "you seem as interested in me as in my diabetes." All modifications in the

biomedical management were discussed openly, and she remained extremely cooperative. The resident felt all of his anger, frustration, guilt, and rejection evaporate from the relationship. He felt that he had truly helped by really "doing nothing."

Summary

Physicians may profitably ask themselves the question, "Is what I am doing (surgical procedure, writing a prescription, or advising) to relieve my helplessness by feeling obliged to do something, or is it truly to benefit a known, treatable fully-evaluated condition of the patient?" The art of "doing nothing" requires physicians to change some of the prevalent attitudes about helping people and to focus on healing rather than curing. It involves avoiding "doing something," getting the patient's story, maximizing the physician's charisma, inviting patients to return, and using a "tincture of time." It is obvious that a physician can always move from a "do nothing" stance to a "do something" approach if medically necessary, but it is very difficult to move in the opposite direction.

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Alcohol and Unintentional Injury: Beyond the Motor Vehicle

Connection Between Alcohol Ingestion and Unintentional Nonvehicular Injuries Is Focus of Review

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Injuries are the fourth leading cause of death in the United States after heart disease, cancer, and cerebrovascular disease.[1] But more importantly, they are the leading killer of Americans between the ages of one and 44,[2] and are consequently ranked first in terms of the most widely used indicator of premature mortality, namely, "potential years of life lost between ages one and sixty-five."[3]

While the pertinent morbidity data are grossly deficient, it is clear that the mortality figures represent only the tip of the injury iceberg. For example, national data for 1980 indicate that injuries were the leading cause of physician contacts and accounted for more than one quarter of hospital emergency room visits.[4] Despite the enormity of the problem, injuries have been relatively neglected by the scientific community.[5] However, aided by a substantial infusion of federal funds, the Centers for Disease Control (CDC) are spearheading concerted efforts to reverse the legacy of that neglect.[6]

Another major public health problem that is receiving inadequate funding, and thus inadequate research attention, is that of the negative health effects of alcohol ingestion.[7] But it should be added that The National Institute on Alcohol and Alcohol Abuse (NIAAA) is active in stimulating such research. Given the adverse physiologic effects of prolonged or heavy alcohol ingestion,[8] as in the form of impaired fine and gross motor control, it is not surprising that injuries are intimately linked to alcohol abuse. This relationship is at issue in this paper. More specifically, the alcohol connection is examined with respect to nonvehicular unintentional injuries. While this relationship has been overshadowed in the literature by studies of the links between alcohol and vehicular injury on the one hand, and alcohol and violence on the other, it nonetheless warrants serious consideration given the magnitude of nonvehicular unintentional injury. Data for 1982 reveal that the latter accounted for 52 per cent of unintentional injury mortality in the United States.[6] Averaged triennial data for the period 1980-1982 indicate that the corresponding Rhode Island figure was even higher at 60 per cent.

Injury mortality serves as the initial focus. Attention then shifts to injury morbidity. Issues of data quality are raised in reference to both categories. Mention is then made of three continuing studies related to alcohol and injuries, that should shed more light on this relationship. Finally, suggestions are proferred concerning data needs and countermeasures.

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Injury Mortality

While nonvehicular unintentional injury is the outcome of interest, it must be acknowledged that there is a grey area between intentional and unintentional injury:

> Many persons addicted to alcohol live alone, and they die alone, unwitnessed, in a variety of ways. They are found in rivers in the cold of winter, and one cannot determine, for example, if they slipped on the ice and fell through, deliberately jumped,

or were pushed into the water. So it is with many alcoholics dying from closed head trauma or from a combination of drugs, including alcohol.[9]

Measuring alcohol ingestion, and defining and assessing alcohol abuse, too, have proven formidable and often elusive tasks.[10] Thus, much of the reported research that follows can only be viewed as suggestive. Control groups are typically lacking. Measurement is often tenuous and poorly recorded, and sample size is frequently small. Nevertheless, the weight of the evidence remains compelling.

A study of medical examiner's records in the District of Columbia found that 55 per cent of 80 nonvehicular unintentional injury deaths were associated with alcohol ingestion.[9] Not only is alcohol directly implicated in these deaths, but indirectly as well. Seven of the victims (nine per cent) ultimately died as a result of the inebriated state of others charged with their personal safety. For example, it was determined that two young children perished in a house fire because their father was alcohol-impaired.

Waller, one of the pioneers in injury control research, carried out a study of the county coroner's records in Sacramento, California.[11] Concentrating on the population over 14 years of age, he found that alcohol was present in 42 per cent of 108 nonvehicular unintentional injury fatalities, while it was present in only 18 per cent of the control group. The control group comprised coroner's cases who died of nontraumatic illness. Such a control is essential to determine whether coroner's injury cases in particular, or all coroner's cases, are highly alcohol-related.

Falls are the leading cause of nonvehicular unintentional injury deaths in the United States.[12] In the *Fifth Special Report to Congress on Alcohol and Health*,[10] it was estimated that 40 per cent of fall fatalities were tied to alcohol. In the Sacramento study,[11] it was found that 70 per cent of fatal fall victims had measurable blood alcohol concentrations, and 60 per cent had concentrations equal to or in excess of 0.10 per cent (100 milligrams per 100 milliliters). A New York City study revealed that 41 per cent of fall victims registered blood alcohol concentrations of 0.10 per cent or higher.[13] In another study conducted in Erie County in New York State, it was determined that 21 per cent of fall fatalities had such a concentration.[14] It is important to note that the Erie County study included persons who died within eight hours of the injury event. By comparison, Waller employed a six-hour cut-off point.[11] He argues that negative blood alcohol readings obtained from people who survive beyond six hours are meaningless. Any alcohol ingested may have already been metabolized.

Drownings and fires comprise the final categories of injury mortality that are specifically addressed in this paper. Data for 1980 indicate that they follow falls as the most important external causes of nonvehicular unintentional injury fatalities in the United States.[12] Averaged triennial data for 1980-1982 show a similar situation in Rhode Island.[15]

In an Australian study of drowning deaths, Plueckhahn states that in:

> a significant proportion of the accidental drownings which occurred in adults . . . the deceased person did not appear to struggle or surface following immersion and even when pulled from the water almost immediately was found to be dead . . . the fatal event was generally much more typically a cardiac death than . . . a respiratory death.[16]

He goes on to say that, while the suggestion of a "heart attack" was common, autopsy typically yielded no evidence of heart disease, injury, or suffocation. Instead, a high blood alcohol concentration was manifest. The possibility that people drown after losing consciousness due to alcohol intoxication needs further exploration. Similar events occur on the highway, when intoxicated drivers "fall asleep" at the wheel and consequently swerve off the road or into adjacent or oncoming traffic.

Berkelman et al studied the medical examiner's records in Fulton County, Georgia.[17] Of 13 drowning victims, who were between the ages of 24 and 62 years, it was determined that about 70 per cent ($n = 9$) had blood alcohol concentrations of 0.10 per cent or higher. The authors utilized Waller's six-hour survival cut-off point. In the New York City study cited previously, 53 per cent of 19 drowning victims were at the 0.10 per cent blood alcohol level or higher.[13]

Alcohol use and alcoholism appear to play a major causal role in fires that often have adverse injury outcomes extending beyond the alcohol-troubled individual who was responsible for the fire. Drinking and smoking interact in fire causation. It has been observed that positive blood alcohol concentrations are manifest in three times as many cigarette-induced fire situations as in those not linked to cigarettes.[18] In Canada, Ducik and Ghezzo conducted a case-control study and discovered that the principal determinant of serious house fires was the number of alcohol users who were residents in the building affected.[19] The relationship was positive. In terms of epidemiologic impact, the *Third Special Report to the*

US Congress on Alcohol and Health states that:

> Alcohol lowers oxidation in the cells and increases a person's chances of succumbing to smoke inhalation and suffocation. In addition, cloudy judgment and slow reflexes may make escape or rescue more difficult.[8]

Data from the Sacramento study reveal that 64 per cent of fire victims had blood alcohol concentrations of 0.10 per cent or higher.[11] The corresponding figure in the New York City study was 46 per cent.[13] In the Fulton County study, it was found that, of 30 fatal fire victims aged between 24 and 86 years who died within six hours of the incident, 77 per cent had ingested alcohol.[17] Moreover, 63 per cent registered blood alcohol readings of 0.10 per cent or higher.

Injury Morbidity

Despite the large number of cases available for study, difficulties with the quality of alcohol-related injury mortality studies are compounded when the outcome determination is morbidity. Solomon et al contend that physicians carry their own sets of emotional and cultural baggage that can hamper their abilities accurately to detect, diagnose, and hence quantify alcohol use among their patients.[20] In their study of a sample of emergency room physicians, these researchers uncovered a gross discrepancy between the percentage of patients they identified as alcoholic or alcohol abusers, and the percentage reported by the physicians. The latter, who were not given specific training in identifying problem drinkers, were underestimating the reality. Clinical assessment of alcohol involvement by such methods as detection of alcohol on the breath or evaluating a staggering gait, slurred speech patterns, or aggressive or otherwise inappropriate behavior is subject to substantial error. For example, some of this aberrant behavior may be a product of drug use other than alcohol, or of some unrecognized illness that mimics the symptoms of alcoholism, such as diabetes or multiple sclerosis.

Physician and other provider underreporting of alcohol involvement may partly reflect either implicit rejection of the disease model of alcoholism or the belief that recording alcohol use is not uniformly of clinical relevance. However, the barriers to remedying the situation transcend both physician denial and biases based on social class, sex, age, race, and ethnicity. Physicians are often well-attuned to the fears of hospital or health maintenance organization (HMO) administrations regarding litigation concerning any alleged breach of confidentiality. A related issue is that physicians and administrators are reluctant to lose valuable physician time to the demands of court testimony.

The fact that less severely injured individuals can deliberately delay an emergency room visit, or bypass the emergency room system altogether, also hampers efforts to obtain accurate data regarding the role of alcohol in causing injury. Furthermore, it is important to re-emphasize that blood alcohol readings must be taken within at least six hours of these events.

Examples of emergency room studies of alcohol-related nonvehicular unintentional injury morbidity are rare, regardless of quality. One well-controlled study was conducted in a large hospital in Boston, Massachusetts by Wechsler et al.[21] The study and comparison groups were drawn from patients over 15 years of age, who were seen in the emergency room over the course of a year. Blood alcohol concentrations were measured principally with a breathalyzer. Where use of this technique proved infeasible, efforts were made to obtain the evidence from a venous blood sample. In addition, interviewers endeavored to ascertain whether there was evidence of "alcohol on breath" at the time of emergency room visit. Supplementary information on drinking behavior and sociodemographic background characteristics was obtained from the interviews and from hospital records.

The Boston study revealed that about 22 per cent of 620 home injury cases who were breath-tested had positive blood alcohol concentrations.[21] Half of them registered readings of 0.05 per cent or higher. By comparison, less than 10 per cent of 2,633 noninjury cases yielded positive blood alcohol readings. Although the samples were smaller, persons whose alcohol status was measured by either of the two alternative methods, that is, through blood samples or on the basis of "alcohol on breath," showed positive alcohol involvement in almost 18 per cent of home injury cases ($n = 62$) and only four per cent of noninjury cases ($n = 892$). Occupational injury cases manifested a smaller proportion of positive blood alcohol concentrations than home injury cases, but the figure was still substantially higher than that for noninjury cases. The proportion detected with the breathalyzer was about 15 per cent, while that with the alternative measures was 13 per cent.

These findings still obtained when controls were implemented with respect to drinking after the injury event or symptoms precipitating the emergency room visit. This was also the case when sex, age, social class, marital status, and duration

between injury/illness and visit were controlled. Race and ethnicity were not considered. Wechsler et al also found that positive alcohol readings were distributed equally among the home injury cases in terms of major categories of external cause, namely, cutting and piercing, falls, fires, and collisions.

In a recent study of a sample of 2,516 emergency room patients at San Francisco General Hospital, 23 per cent of injury cases had positive breathalyzer readings, a significantly higher percentage than that of noninjury cases.[22] A similarly high degree of alcohol involvement was observed by Wechsler et al.[21] This contrasts with the low incidence (1.4 per cent) found by Amdur in his emergency room study.[23] Solomon et al point to the discrepancy in these results to question the validity of relying on a retrospective review of emergency room data to assess alcohol status.[20] Unlike Wechsler et al, Amdur resorted to the retrospective approach.

In a study of 94 home injury cases, Kirkpatrick and Taubenhaus report that intoxicated persons (defined as having a blood alcohol concentration in excess of 0.15 per cent) incurred less severe injuries than their more sober counterparts.[24] This is consistent with a popular notion that the former are likely to be more relaxed than the latter at the time of injury, and hence are relatively more protected. Honkanen and Visuri confirm the severity finding in a Finnish study, but they suggest that this "could partially be the result of (unnecessarily) intensive care of the intoxicated until injury as a cause of unconsciousness has been ruled out."[25]

Given the prevailing uncertainty, it is imperative to investigate further the relationship between alcohol ingestion and injury severity. Severity should be measured as an interval scale variable such as the Injury Severity Score, which is based on the Abbreviated Injury Scale.[26-28]

Clearly, objective quantifiable measures of alcohol use among patients are strongly preferable to observational measures. Reference has been made to two objective measures, namely, blood and breath testing. A third measure is the dipstick. This newly developed technology enables alcohol to be detected in saliva, urine, or serum.[29, 30] Quantification is cruder than that obtained through the other two measures, and the technology is still being refined. However, on a more positive note, the dipstick may prove less threatening to patients than the other measures and thus enhance participation in epidemiologic studies concerned with alcohol use.

Some Current Studies

Both injury control and alcoholism and alcohol abuse research are, to borrow a phrase from the political economist W. W. Rostow, in the stage of "take-off."[31] The important relationship between the two and the extent of the ignorance concerning its exact nature have not been lost on NIAAA and CDC. NIAAA has channeled funds through CDC to support two potentially landmark studies that are examining the alcohol-injury nexus from different perspectives.

The first study, which is being implemented by Johns Hopkins University, is examining the feasibility of establishing a population-based surveillance system to monitor alcohol-related injuries in terms of their nature and severity.[32] Data sources are emergency room charts, hospital records, and medical examiner's records. The geographic area of study comprises the city of Baltimore and the five adjacent counties. It is anticipated that it will be possible to make rural-urban distinctions and comparisons between whites and non-whites. Breathalyzers are being used to measure blood alcohol concentrations in the emergency rooms. To the same end, blood tests are being administered in the cases of those severely injured patients who are transferred to a trauma center for treatment.

A longer-term goal of the surveillance system, should it prove feasible, is to evaluate interventions aimed at reducing alcohol-related injuries and their severity. The second NIAAA-CDC-sponsored study is, in fact, a community-based surveillance and intervention study.[33] It is being conducted by the Rhode Island Department of Health and is expected to last four years. The study involves three Rhode Island communities, and a major component is data collection on a sample of all injury and illness cases presenting at hospital emergency rooms. There is a provision for internal controls. At the time of writing, the nature of the study interventions has not been finally established.

A further study utilizes linked records from an HMO. Specifically, a hypothesis is being tested that children in intact families with an alcoholic parent manifest higher injury rates than children in matched families with non-alcoholic parents. A conservative bias is likely to operate because alcoholics are defined as those who have been so identified in counseling. This group of alcoholics represents rarely studied individuals, those who have a relatively low level of familial and work role impairment despite their problem drinking.

The aims of this study, which is being conducted by the authors of this paper, further reflect recognition of the fact that the alcohol-injury relationship is not always direct. For example, living with familial alcoholism may be an important injury risk factor among children due to elevated shared exposures to events such as house fires and motor vehicle crashes, greater parental neglect and child abuse, and the increased likelihood that children with an alcoholic parent or parents will "act out" to seek attention or become careless as a result of depression or preoccupation.

Data Needs and Countermeasures

If the alcohol-injury relationship is to be understood and successfully addressed through application of effective interventions or countermeasures, it is necessary to upgrade the quality of data on both alcohol ingestion and injury morbidity. The quality of injury mortality data tends to be reasonably good in the United States. However, the morbidity data could be markedly improved if E-codes (external causes) were routinely reported in hospital and emergency room records. It is noteworthy that the Rhode Island Department of Health is collaborating with the Johns Hopkins University on a CDC-sponsored project, which is ultimately aimed at improving the coverage and accuracy of E-coding in hospitals, both in Rhode Island and throughout the nation.

Alcohol data present an even more formidable challenge with regard to quality than injury morbidity data because of their potentially controversial character. However, there are two overriding reasons for routinely recording alcohol information on all injury cases. The first relates to the capacity to provide appropriate medical care,[11] and is especially important in cases of head trauma.[22,34] The second reason concerns detection, often early, of problem drinking[35] and the concomitant potential for referring alcohol-troubled persons to treatment. Maull[34] recommends that appropriately trained personnel should be an integral part of the staff on all acute trauma units.

Obviously, an important source of countermeasures against alcohol-related injury and repeat injury is the health care system. However, injuries can be avoided and their severity reduced in the short run, through pervasive application of passive countermeasures at the locus of possible injury events.[36] This approach emphasizes modification of the environment rather than modification of individual behavior. Examples of passive countermeasures abound. They include fire-resistant fabrics, smoke detectors, swimming pool fences, child-proof containers, and staircase guardrails.

Although the effectiveness of passive countermeasures in diminishing injury is undeniable, it is important that they be complemented by public education on both alcohol use and injury prevention. This education should be continuous, as the human retention span is often short. It should be viewed as a longer-term rather than a short-term intervention strategy. Moreover, it must start with the elementary school segment of the pediatric population, since only those who abstain from alcohol can avoid alcoholism with absolute certainty.

While prevention efforts still fall short of maturity, the adverse relationship between drinking and driving is generally well acknowledged by society.[37] Much less appreciated is the etiologic connection between alcohol ingestion and nonvehicular unintentional injuries, a connection of profound importance in view of the evidence presented here. Relevant research activities are increasing, and in turn they will heighten societal awareness of the alcohol-injury nexus and promote prevention. However, even greater progress could be achieved if responsibility for alcohol, as well as for firearms and tobacco, became an integral part of the public health domain.[38] Currently, these three major vehicles of injury and disease fall under the control of the Department of Treasury. This administrative arrangement inevitably underscores their revenue-generating capacity and detracts from their lethal potential.

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• • •

While growth hormone can correct short stature, it does not necessarily assure a normal productive life, according to a report in the November 1985 issue of the *American Journal of Diseases of Children*. In a study of 116 Canadian adults who had been treated with growth hormone, researchers found that unemployment rates were much higher and that marriage rates were much lower than national norms. The study included 86 men and 30 women between the ages of 18 and 38, most of whom had completed formal education comparable to their siblings and peers. Among the findings: 25.4 per cent were unemployed with rates for those younger than 25 years of age 45 per cent and those 25 years and older 23 per cent. National averages for these age groups were 21.2 per cent and 9.4 per cent respectively. The percentage of those married was less than 30 per cent of the expected age-adjusted rate.

"Before treatment, children with growth hormone deficiency have been described as being socially isolated and psychologically immature," say Doctor Heather J. Dean and her colleagues from the University of Manitoba in Winnipeg. "After one or two years of growth therapy, many of these children have persistent severe personality difficulties despite increased linear growth."

Their evaluation of the social outcome of treated patients underscores severe therapeutic failings. Of the 90 patients not attending school, 70 still lived with parents or relatives. Puberty occurred spontaneously in 63 per cent of the pa-

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tients. The remaining 37 per cent were receiving sex steroid replacement therapy at the time of the study. Only 13 per cent were married as compared with the national average of 71.1 per cent for their age group, and only 55 per cent of the unmarried patients were dating regularly.

The researchers conclude that new patient management strategies are needed, including the design of specific goal-oriented psychotherapeutic programs. "Since increased height does not necessarily lead to normal social integration in adult life, the goals of growth hormone therapy for normal short children must be carefully, but urgently, evaluated in view of the future unlimited supply of growth hormone produced by recombinant DNA technology."

• • •

A report of a fatal bacterial infection after a blood transfusion appears in the November 1985 issue of the *Archives of Pathology and Laboratory Medicine*, prompting an editorial warning to physicians to be alert to bacterial as well as other blood contaminants. Dr. D. Craig Wright and his colleagues from the Walter Reed Army Medical Center in Washington, DC report on a 61-year-old bypass patient who received blood contaminated with *Yersinia enterocolitica*, which led to septic shock and death. While uncommon, bacterial blood contamination clearly can be as dangerous as contamination by hepatitis or HTLV-III viruses, comments Doctor Byron A. Myhre of the UCLA School of Medicine. "A considerable portion of these reactions are preventable by good history-taking and good technique," he adds.

• • •

The Hewlett-Packard Company has announced a new, fully integrated quantification software package for the HP 77020 AC/AR phased-array Doppler imaging systems. This software allows a physician or sonographer to obtain real-time Doppler measurements and calculations during a patient's visit and retain them for playback. The need for the patient to return for additional scanning can be reduced as can the time spent making manual calculations at the end of the day. Moreover, real-time data can provide surgeons with the quantitative, decision-making information they need to determine whether further testing is required.

There are four reports available in the package. Each includes a specific set of calculations and measurements grouped according to the specific Doppler study desired. The four reports are: pressure gradients, pressure half-times, flow

volumes, and user-configurable. For each of the four functional study groups, there is a complete measurement menu available and a corresponding full-screen report, which summarizes data in a clear, concise one-page report.

A track-ball, conveniently placed on the keyboard for easy access during studies, can be used for tracing irregular anatomical structures. In two-dimensional studies, the area of interest can be computed by simply tracing the boundary. In Doppler studies, the velocity spectrum can be traced with the trackball to give the area under the curve.

All existing HP phased-array owners may add the complete HP Doppler quantification analysis package to their present Doppler systems. The package will be standard on all new phased-array Doppler imaging systems delivered after December 31, 1985.

• • •

Hay fever is the most common allergic disease in this country, affecting between 18 and 20 million Americans, according to the report *Hay Fever*, published by the American Council on Science and Health (ACSH). The Council is an independent, nonprofit consumer education organization promoting scientifically balanced evaluations of food, chemicals, the environment, and health. It may also be one of the most misunderstood diseases, and the confusion starts with its name. The allergic reaction is rarely associated with hay, and fever is not one of its symptoms, the report states.

"One common myth is that colorful, sweet-smelling flowers that attract insects are the major culprits in hay fever," said Doctor Alan Fisher, co-author of the ACSH report. "However, these plants actually have heavy pollen grains which don't easily become airborne. The real villains are plants that often go unnoticed because they are dull-looking and odorless."

Some hay fever sufferers buy air cleaning systems to filter dust, pollen, or mold spores from the air in their homes. However, filtering devices that attach to central heat and air conditioning systems can be expensive, the ACSH report warns, and portable devices may be good only for a small area. Most portable devices filter only pollen, not spores, so that they are of limited value to individuals who are allergic to mold spores. ACSH advises consumers to read labels carefully when purchasing such a machine and to make sure that the device is approved by the US Food and Drug Administration for allergies.

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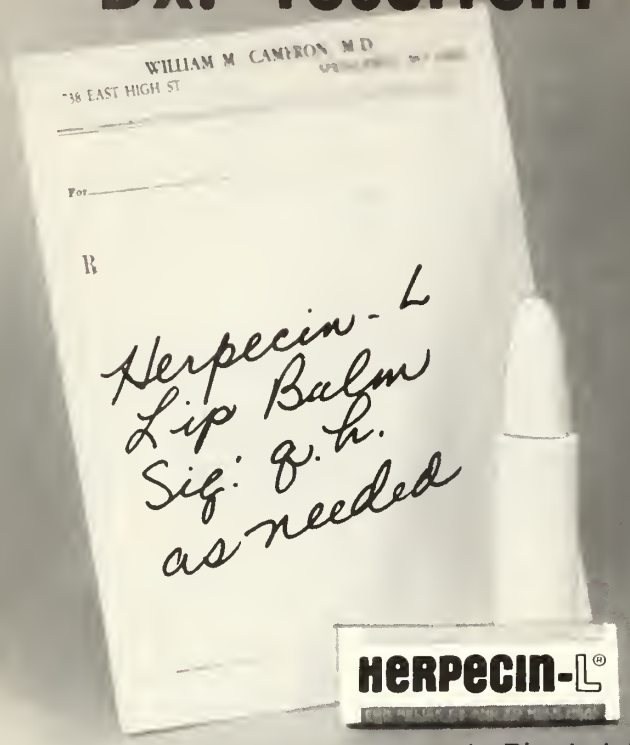
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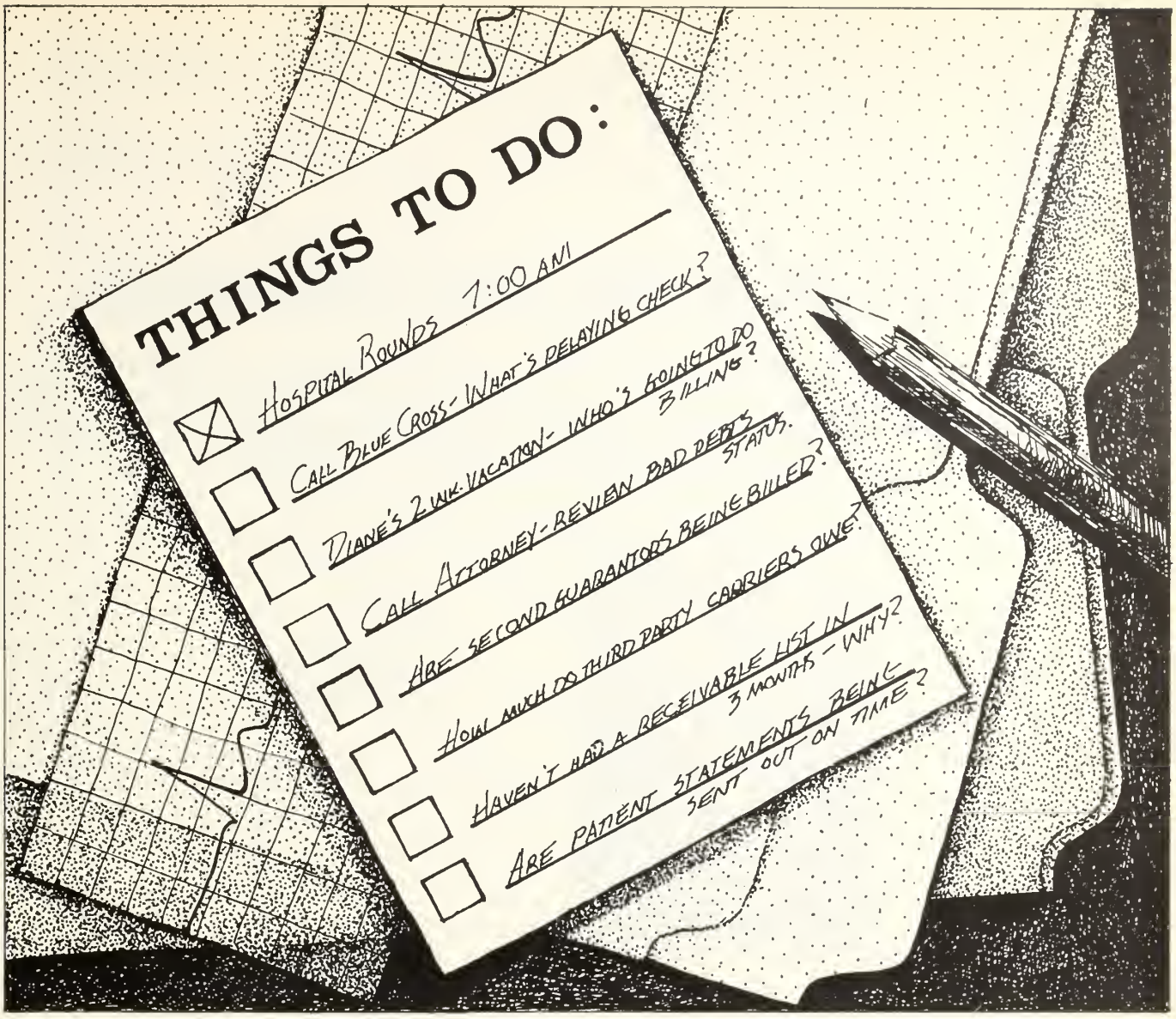
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SUSPECTED ADVERSE REACTION REPORT (For All Drugs and Biologics)

IMPORTANT: SUBMISSION OF A REPORT DOES NOT NECESSARILY CONSTITUTE AN ADMISSION THAT THE DRUG CAUSED THE ADVERSE REACTION

PATIENT INITIALS (Optional)	AGE (Years)	SEX ☐ MALE ☐ FEMALE	DATE OF REACTION ONSET

DESCRIBE REACTION(S) (Give signs, symptoms, diagnoses, course and lab findings)

CHECK ALL APPROPRIATE TO REACTION
- DIED
- TREATED WITH Rx DRUG
- INPATIENT HOSPITALIZATION
- SEVERE OR PERMANENT DISABILITY
- EMERGENCY ROOM TREATMENT
- TREATMENT IN PHYSICIAN OFFICE
- NONE OF THE ABOVE

SUSPECTED DRUG(S) (Trade Name is preferred. If a generic product, give manufacturer. Indicate Lot No. for vaccines, biologics.)

REASON FOR USE OF DRUG(S)	ROUTE	TOTAL DAILY DOSE	DATES OF ADMINISTRATION

OTHER DRUGS TAKEN CONCOMITANTLY (Exclude those used to treat reaction)

OTHER RELEVANT HISTORY (e.g. Concomitant Diagnoses, Pregnancy, etc.)

PHYSICIAN NAME AND TELEPHONE NUMBER

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ALSO REPORTED TO MANUFACTURER ☐ YES ☐ NO

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CARDIOVASCULAR:
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- LOZAL (indapamide)
- TONOCARD (tocainide)
- WYTENSIN (guanabenz acetate)
- CARDIZEN (diltiazem)
- NORMODYNE or TRANDATE (labetalol)
- VISKEN (pindolol)

HEMORHEOLOGIC AGENT:
- TRENTAL (pentoxityltine)

HYPOGLYCEMICS:
- GLUCOTRAL (glipizide)
- MICRONASE or DIABETA (glyburide)

NONSTEROIDAL ANTIINFLAMMATORY:
- FELDENE (piroxicam)
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OTHER:
- ZANTAC (ranitidine)
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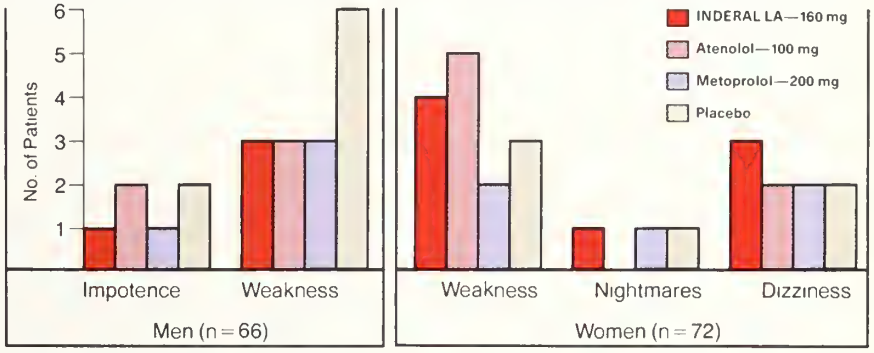
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INDERAL LA should not be used in the presence of congestive heart failure, sinus bradycardia, cardiogenic shock, heart block greater than first degree, and bronchial asthma.

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INDERIDE® LA Brand of PROPRANOLOL HYDROCHLORIDE (INDERAL® LA) and HYDROCHLOROTHIAZIDE **(Long Acting Capsules)**

INDERAL LA and INDERIDE LA Capsules should not be considered simple mg-for-mg substitutes for INDERAL and INDERIDE Tablets. Please see package circulars.

CONTRAINDICATIONS

Propranolol hydrochloride (INDERAL® LA): Propranolol is contraindicated in 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with propranolol.

Hydrochlorothiazide: Hydrochlorothiazide is contraindicated in patients with anuria or hypersensitivity to this or other sulfonamide-derived drugs.

WARNINGS

Propranolol hydrochloride (INDERAL® LA): CARDIAC FAILURE. Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated, and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely; or propranolol should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction following *abrupt* discontinuance of propranolol therapy. Therefore, when discontinuance of propranolol is planned the dosage should be gradually reduced and the patient carefully monitored. In addition, when propranolol is prescribed for angina pectoris, the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If propranolol therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute propranolol therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

Nonallergic Bronchospasm (eg, chronic bronchitis, emphysema)— PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD, IN GENERAL, NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution, since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin. Hypoglycemic attacks may be accompanied by a precipitous elevation of blood pressure.

Hydrochlorothiazide: Thiazides should be used with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. In patients with impaired renal function, cumulative effects of the drug may develop.

Thiazides should also be used with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma.

Thiazides may add to or potentiate the action of other antihypertensive drugs. Potentiation occurs with ganglionic or peripheral adrenergic-blocking drugs.

Sensitivity reactions may occur in patients with a history of allergy or bronchial asthma.

The possibility of exacerbation or activation of systemic lupus erythematosus has been reported.

PRECAUTIONS

Propranolol hydrochloride (INDERAL® LA): GENERAL: Propranolol should be used with caution in patients with impaired hepatic or renal function. Propranolol is not indicated for the treatment of hypertensive emergencies.

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that propranolol may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

CLINICAL LABORATORY TESTS: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs, such as reserpine, should be closely observed if propranolol is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity, which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies, in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

PREGNANCY: Pregnancy Category C. Propranolol has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximal recommended human dose. There are no adequate and well-controlled studies in pregnant women. Propranolol should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

NURSING MOTHERS: Propranolol is excreted in human milk. Caution should be exercised when propranolol is administered to a nursing mother.

PEDIATRIC USE: Safety and effectiveness in children have not been established.

Hydrochlorothiazide: GENERAL: Periodic determination of serum electrolytes to detect possible electrolyte imbalance should be performed at appropriate intervals.

All patients receiving thiazide therapy should be observed for clinical signs of fluid or electrolyte imbalance, namely: Hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when the patient is vomiting excessively or receiving parenteral fluids. Medication such as digitalis may also influence serum electrolytes. Warning signs irrespective of cause are: Dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea and vomiting.

Hypokalemia may develop, especially with brisk diuresis, when severe cirrhosis is present, or during concomitant use of corticosteroids or ACTH.

Interference with adequate oral electrolyte intake will also contribute to hypokalemia. Hypokalemia can sensitize or exaggerate the response of the heart to the toxic effect of digitalis (eg, increased ventricular irritability). Hypokalemia may be avoided or treated by use of potassium supplements, such as foods with a high potassium content.

Any chloride deficit is generally mild and usually does not require specific treatment, except under extraordinary circumstances (as in liver or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction, rather than administration of salt, except in rare instances when the hyponatremia is life-threatening. In actual salt depletion, appropriate replacement is the therapy of choice.

Hyperuricemia may occur or frank gout may be precipitated in certain patients receiving thiazide therapy.

Insulin requirements in diabetic patients may be increased, decreased, or unchanged. Diabetes mellitus which has been latent may become manifest during thiazide administration.

If progressive renal impairment becomes evident, consider withholding or discontinuing diuretic therapy.

Thiazides may decrease serum PBI levels without signs of thyroid disturbance.

Calcium excretion is decreased by thiazides. Pathologic changes in the parathyroid gland with hypercalcemia and hypophosphatemia have been observed in a few patients on prolonged thiazide therapy. The common complications of hyperparathyroidism, such as renal lithiasis, bone resorption, and peptic ulceration, have not been seen. Thiazides should be discontinued before carrying out tests for parathyroid function.

DRUG INTERACTIONS: Thiazide drugs may increase the responsiveness to tubocurarine.

The antihypertensive effects of thiazides may be enhanced in the postsympathectomy patient. Thiazides may decrease arterial responsiveness to norepinephrine. This diminution is not sufficient to preclude effectiveness of the pressor agent for therapeutic use.

PREGNANCY: Pregnancy Category C. Thiazides cross the placental barrier and appear in cord blood. The use of thiazides in pregnancy requires that the anticipated benefit be weighed against possible hazards to the fetus. These hazards include fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult.

NURSING MOTHERS: Thiazides appear in human milk. If use of the drug is deemed essential, the patient should stop nursing.

PEDIATRIC USE: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Propranolol hydrochloride (INDERAL® LA): Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: Bradycardia, congestive heart failure, intensification of AV block, hypotension, paresthesia of hands, thrombocytopenic purpura, arterial insufficiency, usually of the Raynaud type.

Central Nervous System: Lightheadedness, mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to catatonia, visual disturbances, hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: Nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: Pharyngitis and agranulocytosis; erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: Bronchospasm.

Hematologic: Agranulocytosis; nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: Alopecia, LE-like reactions, psoriasiform rashes; dry eyes; male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes, and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

Hydrochlorothiazide:

Gastrointestinal: Anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation, jaundice (intrahepatic cholestatic jaundice); pancreatitis, sialadenitis.

Central Nervous System: Dizziness, vertigo, paresthesias, headache, xanthopsia.

Hematologic: Leukopenia, agranulocytosis, thrombocytopenia, aplastic anemia.

Cardiovascular: Orthostatic hypotension (may be aggravated by alcohol, barbiturates, or narcotics).

Hypersensitivity: Purpura, photosensitivity, rash, urticaria, necrotizing angiitis (vasculitis, cutaneous vasculitis), fever, respiratory distress, including pneumonitis, anaphylactic reactions.

Other: Hyperglycemia, glycosuria, hyperuricemia, muscle spasm, weakness, restlessness, transient blurred vision.

Whenever adverse reactions are moderate or severe, thiazide dosage should be reduced or therapy withdrawn.

* The appearance of these capsules is a registered trademark of Ayerst Laboratories

REFERENCE:

1. Ravid M, Lang R, Jutrin I. The relative antihypertensive potency of propranolol, oxprenolol, atenolol, and metoprolol given once daily. *Arch Intern Med* 1985;145:1321–1323.

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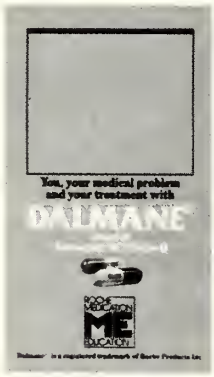
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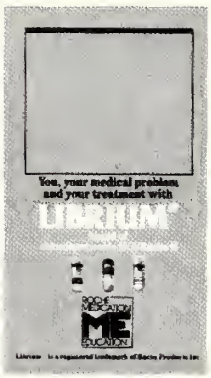
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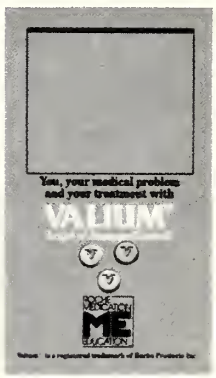
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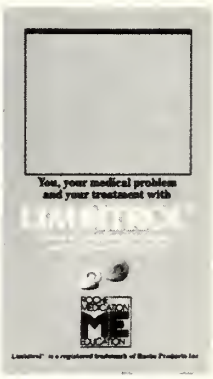
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Rhode Island
Medical Journal

October 1986
Volume 69, Number 10



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There's never been a better time for her... and PREMARIN®
(Conjugated Estrogens Tablets)

Now the evidence looks better than ever

Significantly reduced risk of endometrial hyperplasia

Endometrial hyperplasia was significantly reduced when progestin was added to PREMARIN therapy for more than ten days a month.[1-4] The risk of endometrial hyperplasia may also be reduced through cyclic administration of unopposed, low-dose PREMARIN.

Effect on lipids—an important feature

PREMARIN used alone does not adversely affect lipid levels. In fact, a clinical study has shown a significant increase in HDL cholesterol—from 49.7 mg/dL to 56.4 mg/dL—and decrease in LDL cholesterol—from 165.1 mg/dL to 138.1 mg/dL—after one year of therapy with PREMARIN, 0.625 mg.[5]

Low-dose control of menopausal symptoms*

PREMARIN effectively relieves vasomotor symptoms, such as hot flashes. When estrogen deficiency is limited to atrophic vaginitis, PREMARIN® (conjugated estrogens) Vaginal Cream restores the vaginal environment to its premenopausal state.

The most widely used, most extensively studied estrogen worldwide.

PREMARIN®
(Conjugated Estrogens Tablets)

Most trusted for more reasons

*PREMARIN is indicated for moderate-to-severe vasomotor symptoms.

Please see following page for brief summary of prescribing information.

For moderate-to-severe vasomotor symptoms

PREMARIN®
(Conjugated Estrogens Tablets)



0.3 mg 0.625 mg 0.9 mg 1.25 mg 2.5 mg

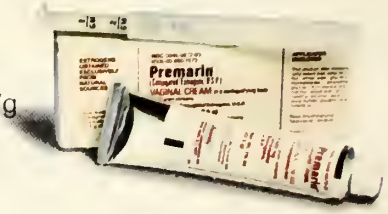
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For atrophic vaginitis

PREMARIN®
(Conjugated Estrogens)

Vaginal Cream

0.625mg/g



BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION AND PATIENT INFORMATION, SEE PACKAGE CIRCULARS.)*

PREMARIN® Brand of conjugated estrogens tablets, USP
PREMARIN® Brand of conjugated estrogens Vaginal Cream in a nonliquefying base

1. ESTROGENS HAVE BEEN REPORTED TO INCREASE THE RISK OF ENDOMETRIAL CARCINOMA

Three independent case control studies have reported an increased risk of endometrial cancer in postmenopausal women exposed to exogenous estrogens for more than one year. This risk was independent of the other known risk factors for endometrial cancer. These studies are further supported by the finding that incidence rates of endometrial cancer have increased sharply since 1969 in eight different areas of the United States with population-based cancer reporting systems, an increase which may be related to the rapidly expanding use of estrogens during the last decade. The three case control studies reported that the risk of endometrial cancer in estrogen users was about 4.5 to 13.9 times greater than in nonusers. The risk appears to depend on both duration of treatment and on estrogen dose. In view of these findings, when estrogens are used for the treatment of menopausal symptoms, the lowest dose that will control symptoms should be utilized and medication should be discontinued as soon as possible. When prolonged treatment is medically indicated, the patient should be reassessed on at least a semiannual basis to determine the need for continued therapy. Although the evidence must be considered preliminary, one study suggests that cyclic administration of low doses of estrogen may carry less risk than continuous administration; it therefore appears prudent to utilize such a regimen. Close clinical surveillance of all women taking estrogens is important. In all cases of undiagnosed persistent or recurring abnormal vaginal bleeding, adequate diagnostic measures should be undertaken to rule out malignancy. There is no evidence at present that "natural" estrogens are more or less hazardous than "synthetic" estrogens at equiestrogenic doses.

2. ESTROGENS SHOULD NOT BE USED DURING PREGNANCY

The use of female sex hormones, both estrogens and progestogens, during early pregnancy may seriously damage the offspring. It has been shown that females exposed in utero to diethylstilbestrol, a non-steroidal estrogen, have an increased risk of developing in later life a form of vaginal or cervical cancer that is ordinarily extremely rare. This risk has been estimated as not greater than 4 per 1,000 exposures. Furthermore, a high percentage of such exposed women (from 30% to 90%) have been found to have vaginal adenosis, epithelial changes of the vagina and cervix. Although these changes are histologically benign, it is not known whether they are precursors of malignancy. Although similar data are not available with the use of other estrogens, it cannot be presumed they would not induce similar changes. Several reports suggest an association between intrauterine exposure to female sex hormones and congenital anomalies, including congenital heart defects and limb reduction defects. One case control study estimated a 4.7-fold increased risk of limb reduction defects in infants exposed in utero to sex hormones (oral contraceptives, hormone withdrawal tests for pregnancy, or attempted treatment for threatened abortion). Some of these exposures were very short and involved only a few days of treatment. The data suggest that the risk of limb reduction defects in exposed fetuses is somewhat less than 1 per 1,000. In the past, female sex hormones have been used during pregnancy in an attempt to treat threatened or habitual abortion. There is considerable evidence that estrogens are ineffective for these indications, and there is no evidence from well controlled studies that progestogens are effective for these uses. If PREMARIN is used during pregnancy, or if the patient becomes pregnant while taking this drug, she should be apprised of the potential risks to the fetus, and the advisability of pregnancy continuation.

DESCRIPTION: PREMARIN (conjugated estrogens, USP) contains a mixture of estrogens, obtained exclusively from natural sources, blended to represent the average composition of material derived from pregnant mares' urine. It contains estrone, equilin, and 17α-dihydroequilin, together with smaller amounts of 17α-estradiol, equilenin, and 17α-dihydroequilenin as salts of their sulfate esters. Tablets are available in 0.3 mg, 0.625 mg, 0.9 mg, 1.25 mg, and 2.5 mg strengths of conjugated estrogens. Cream is available as 0.625 mg conjugated estrogens per gram.

INDICATIONS AND USAGE: PREMARIN (conjugated estrogens tablets, USP): Moderate-to-severe *vasomotor* symptoms associated with the menopause. (There is no evidence that estrogens are effective for nervous symptoms or depression without associated vasomotor symptoms and they should not be used to treat such conditions.) **Osteoporosis (abnormally low bone mass)**. Atrophic vaginitis. Kraurosis vulvae. Female castration.

PREMARIN (conjugated estrogens) Vaginal Cream is indicated in the treatment of atrophic vaginitis and kraurosis vulvae. PREMARIN HAS NOT BEEN SHOWN TO BE EFFECTIVE FOR ANY PURPOSE DURING PREGNANCY AND ITS USE MAY CAUSE SEVERE HARM TO THE FETUS (SEE BOXED WARNING).

Concomitant Progestin Use: The lowest effective dose appropriate for the specific indication should be utilized. Studies of the addition of a progestin for 7 or more days of a cycle of estrogen administration have reported a lowered incidence of endometrial hyperplasia. Morphological and biochemical studies of the endometrium suggest that 10 to 13 days of progestin are needed to provide maximal maturation of the endometrium and to eliminate any hyperplastic changes. Whether this will provide protection from endometrial carcinoma has not been clearly established. There are possible additional risks which may be associated with the inclusion of progestin in estrogen replacement regimens. (See PRECAUTIONS.) The choice of progestin and dosage may be important; product labeling should be reviewed to minimize possible adverse effects.

CONTRAINDICATIONS: Estrogens should not be used in women (or men) with any of the following conditions: 1. Known or suspected cancer of the breast except in appropriately selected patients being treated for metastatic disease. 2. Known or suspected estrogen-dependent neoplasia. 3. Known or suspected pregnancy. (See Boxed Warning.) 4. Undiagnosed abnormal genital bleeding. 5. Active thrombophlebitis or thromboembolic disorders. 6. A past history of thrombophlebitis, thrombosis, or thromboembolic disorders associated with previous estrogen use (except when used in treatment of breast or prostatic malignancy).

WARNINGS: Long-term continuous administration of natural and synthetic estrogens in certain animal species increases the frequency of carcinomas of the breast, cervix, vagina, and liver. There are now reports that estrogens increase the risk of carcinoma of the endometrium in humans. (See Boxed Warning.) At the present time there is no satisfactory evidence that estrogens given to postmenopausal women increase the risk of cancer of the breast, although a recent study has raised this possibility. There is a need for caution in prescribing estrogens for women with a strong family history of breast cancer or who have breast nodules, fibrocystic disease, or abnormal mammograms. A recent study has reported a 2- to 3-fold increase in the risk of surgically confirmed gallbladder disease in women receiving postmenopausal estrogens.

Adverse effects of oral contraceptives may be expected at the larger doses of estrogen used to treat prostatic or breast cancer or postpartum breast engorgement; it has been shown that there is an increased risk of thrombosis in men receiving estrogens for prostatic cancer and women for postpartum breast engorgement. Users of oral contraceptives have an increased risk of diseases, such as thrombophlebitis, pulmonary embolism, stroke, and myocardial infarction. Cases of retinal thrombosis, mesenteric thrombosis, and optic neuritis have been reported in oral contraceptive users. An increased risk of postsurgery thromboembolic complications has also been reported in users of oral contraceptives. If feasible, estrogen should be discontinued at least 4 weeks before surgery of the type associated with an increased risk of thromboembolism, or during periods of prolonged immobilization. Estrogens should not be used in persons with active thrombophlebitis, thromboembolic disorders, or in persons with a history of such disorders in association with estrogen use. They should be used with caution in patients with cerebral vascular or coronary artery disease. Large doses (5 mg conjugated estrogens per day), comparable to those used to treat cancer of the prostate and breast, have been shown to increase the risk of nonfatal myocardial infarction, pulmonary embolism and thrombophlebitis. When doses of this size are used, any of the thromboembolic and thrombotic adverse effects should be considered a clear risk.

Benign hepatic adenomas should be considered in estrogen users having abdominal pain and tenderness, abdominal mass, or hypovolemic shock. Hepatocellular carcinoma has been reported in women taking estrogen-containing oral contraceptives. Increased blood pressure may occur with use of estrogens in the menopause and blood pressure should be monitored with estrogen use. A worsening of glucose tolerance has been observed in patients on estrogen-containing oral contraceptives. For this reason, diabetic patients should be carefully observed. Estrogens may lead to severe hypercalcemia in patients with breast cancer and bone metastases.

PRECAUTIONS: Physical examination and a complete medical and family history should be taken prior to the initiation of any estrogen therapy with special reference to blood pressure, breasts, abdomen, and pelvic organs, and should include a Papanicolaou smear. As a general rule, estrogen should not be prescribed for longer than one year without another physical examination being performed. Conditions influenced by fluid retention such as asthma, epilepsy, migraine, and cardiac or renal dysfunction, require careful observation. Certain patients may develop manifestations of excessive estrogenic stimulation, such as abnormal or excessive uterine bleeding, mastodynia, etc. Prolonged administration of unopposed estrogen therapy has been reported to increase the risk of endometrial hyperplasia in some patients. Oral contraceptives appear to be associated with an increased incidence of mental depression. Patients with a history of depression should be carefully observed. Preexisting uterine leiomyomata may increase in size during estrogen use. The pathologist should be advised of estrogen therapy when relevant specimens are submitted. If jaundice develops in any patient receiving estrogen, the medication should be discontinued while the cause is investigated. Estrogens should be used with care in patients with impaired liver function, renal insufficiency, metabolic bone diseases associated with hypercalcemia, or in young patients in whom bone growth is not complete. If concomitant progestin therapy is used, potential risks may include adverse effects on carbohydrate and lipid metabolism.

The following changes may be expected with larger doses of estrogen:

a. Increased sulfobromophthalein retention.

b. Increased prothrombin and factors VII, VIII, IX, and X; decreased antithrombin 3; increased norepinephrine-induced platelet aggregability.

c. Increased thyroid binding globulin (TBG) leading to increased circulating total thyroid hormone, as measured by PBI, T4 by column, or T4 by radioimmunoassay. Free T3 resin uptake is decreased, reflecting the elevated TBG; free T4 concentration is unaltered.

d. Impaired glucose tolerance.

e. Decreased pregnanediol excretion.

f. Reduced response to metyrapone test.

g. Reduced serum folate concentration.

h. Increased serum triglyceride and phospholipid concentration. As a general principle, the administration of any drug to nursing mothers should be done only when clearly necessary since many drugs are excreted in human milk.

ADVERSE REACTIONS: The following have been reported with estrogenic therapy, including oral contraceptives: breakthrough bleeding, spotting, change in menstrual flow; dysmenorrhea; premenstrual-like syndrome, amenorrhea during and after treatment, increase in size of uterine fibromyomata; vaginal candidiasis, change in cervical erosion and in degree of cervical secretion; cystitis-like syndrome, tenderness, enlargement, secretion (of breasts); nausea, vomiting, abdominal cramps, bloating, cholestatic jaundice; chloasma or melasma which may persist when drug is discontinued, erythema multiforme, erythema nodosum; hemorrhagic eruption; loss of scalp hair; hirsutism; steepening of corneal curvature; intolerance to contact lenses; headache, migraine, dizziness, mental depression, chorea; increase or decrease in weight; reduced carbohydrate tolerance; aggravation of porphyria; edema; changes in libido.

ACUTE OVERDOSAGE: May cause nausea, and withdrawal bleeding may occur in females.

DOSAGE AND ADMINISTRATION:

PREMARIN® Brand of conjugated estrogens tablets, USP

1. *Given cyclically for short-term use only*: For treatment of moderate to severe *vasomotor* symptoms, atrophic vaginitis, or kraurosis vulvae associated with the menopause (0.3 to 1.25 mg or more daily). The lowest dose that will control symptoms should be chosen and medication should be discontinued as promptly as possible. Administration should be cyclic (eg, three weeks on and one week off). Attempts to discontinue or taper medication should be made at three- to six-month intervals.

2. *Given cyclically*: Female castration. Osteoporosis. Female castration—1.25 mg daily, cyclically. Adjust upward or downward according to response of the patient. For maintenance, adjust dosage to lowest level that will provide effective control. Osteoporosis —0.625 mg daily. Administration should be cyclic (eg, three weeks on and one week off).

Patients with an intact uterus should be monitored for signs of endometrial cancer and appropriate measures taken to rule out malignancy in the event of persistent or recurring abnormal vaginal bleeding.

PREMARIN® Brand of conjugated estrogens Vaginal Cream

Given cyclically for short-term use only: For treatment of atrophic vaginitis or kraurosis vulvae.

The lowest dose that will control symptoms should be chosen and medication should be discontinued as promptly as possible.

Administration should be cyclic (eg, three weeks on and one week off).

Attempts to discontinue or taper medication should be made at three-to-six month intervals.

Usual dosage range: 2 to 4 g daily, intravaginally, depending on the severity of the condition.

Treated patients with an intact uterus should be monitored closely for signs of endometrial cancer and appropriate diagnostic measures should be taken to rule out malignancy in the event of persistent or recurring abnormal vaginal bleeding.

References:

1. Whitehead MI, Townsend PT, Pryse-Davies J, et al: Effects of estrogens and progestins on the biochemistry and morphology of the postmenopausal endometrium. *N Engl J Med* 1981;305:1599-1605. **2**. Paterson MEL, Wade-Evans T, Sturdee DW, et al: Endometrial disease after treatment with oestrogens and progestogens in the climacteric. *Br Med J* 1980;280:822-824. **3**. Magos AL, Brincat M, Studd JWW, et al: Amenorrhea and endometrial atrophy with continuous oral estrogen and progestogen therapy in postmenopausal women. *Obstet Gynecol* 1985; 67: 496-499. **4**. Whitehead MI, Lane G, Siddle N, et al: Avoidance of endometrial hyperstimulation in estrogen-treated postmenopausal women. *Semin Reprod Endocrinol* 1983;1:1;41-52. **5**. Barnes RB, Roy S, Lobo RA: Comparison of lipid and androgen levels after conjugated estrogen or depo-medroxyprogesterone acetate treatment in postmenopausal women. *Obstet Gynecol* 1985;66:216-219.

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Before prescribing, see complete prescribing information in SK&F CO. literature or *PDR*. The following is a brief summary.

* **WARNING**

This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Contraindications: Concomitant use with other potassium-sparing agents such as spironolactone or amiloride. Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: **Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired.** If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

Precautions: The bioavailability of the hydrochlorothiazide component of 'Dyazide' is about 50% of the bioavailability of the single entity. Theoretically, a patient transferred from the single entities of triamterene and hydrochlorothiazide may show an increase in blood pressure or fluid retention. Similarly, it is also possible that the lesser hydrochlorothiazide bioavailability could lead to increased serum potassium levels. However, extensive clinical experience with 'Dyazide' suggests that these conditions have not been commonly observed in clinical practice. Angiotensin-converting enzyme (ACE) inhibitors can elevate serum potassium; use with caution with 'Dyazide'. Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids, and during concurrent use with amphotericin B or corticosteroids or corticotropin [ACTH]). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Cumulative effects of the drug may develop in patients with impaired renal function. Thiazides should be used with caution in patients with impaired hepatic function. They can precipitate coma in patients with severe liver disease. Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic and hemolytic anemia have been reported with thiazides. Thiazides may cause manifestation of latent diabetes mellitus. The effects of oral anticoagulants may be decreased when used concurrently with hydrochlorothiazide; dosage adjustments may be necessary. Clinically insignificant reductions in arterial responsiveness to norepinephrine have been reported. Thiazides have also been shown to increase the paralyzing effect of nondepolarizing muscle relaxants such as tubocurarine. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. Triamterene has been found in renal stones in association with the other usual calculus components. Therefore, 'Dyazide' should be used with caution in patients with histories of stone formation. A few occurrences of acute renal failure have been reported in patients on 'Dyazide' when treated with indomethacin. Therefore, caution is advised in administering nonsteroidal anti-inflammatory agents with 'Dyazide'. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia is uncommon with 'Dyazide', but should it develop, corrective measures should be taken such as potassium supplementation or increased dietary intake of potassium-rich foods. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Concurrent use with chlorpropamide may increase the risk of severe hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function. Thiazides may add to or potentiate the action of other antihypertensive drugs. Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances; postural hypotension (may be aggravated by alcohol, barbiturates, or narcotics). Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and respiratory distress including pneumonitis and pulmonary edema, transient blurred vision, sialadenitis, and vertigo have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components. Rare incidents of acute interstitial nephritis have been reported. Impotence has been reported in a few patients on 'Dyazide', although a causal relationship has not been established.

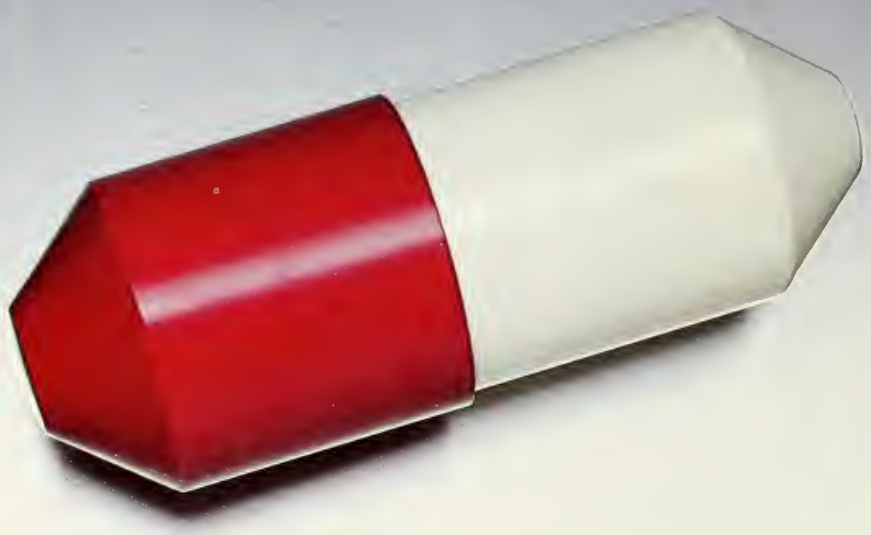
Supplied: **'Dyazide' is supplied as a red and white capsule, in bottles of 1000 capsules; Single Unit Packages (unit-dose) of 100 (intended for institutional use only); in Patient-Pak™ unit-of-use bottles of 100.**

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Jack A. Perkins, Editor

DUES INCREASE

Following the recommendation of the RIMS Council, on September 25 the House of Delegates approved an increase in dues of $100 per member for 1987. In his speech to the House, RIMS President Peter D.T. Clarisse, MD, characterized the additional revenue as "essential" if the Society is to continue to step up its levels of activities. The dues will be $400 per year starting in 1987.

In 1985, a special assessment of $100 from each member was imposed in order to present the RIMS case to the public, press, and legislature concerning the issue of tort reform. As part of this effort it was necessary to improve the image of the Rhode Island physicians. Thus the public relations firm of Duffy and Shanley was retained.

To assist the Society in presenting effectively its positions, John Coffey was engaged to move the tort reform package through the legislature last year. Coffey, "the dean of lobbyists", will be needed again next year. Additionally, the Society procured the services and ideas on tort reform of Professor Jeffrey O'Connell.

RIMS also moved into the legal arena. The Society filed suit against the Department of Business Regulation(DBR) last spring to stop a proposed surcharge on malpractice premiums. The court granted a temporary injunction, and RIMS is currently pressing for a permanent freeze. As a result of this action each physician has saved an average of $2400 on malpractice premiums this year.

Clarisse indicated that the Society is planning to continue to move in this direction. The special assessment has been exhausted, and only with additional revenues can it function effectively. In order to fulfill its responsibilities and strive for quality health care the Society will continue to concentrate on these matters:

- PUBLIC RELATIONS. As a result of recent personnel changes at RIMS, there will be a shift in the responsibilities associated with public relations from Duffy and Shanley to RIMS staff.

- TORT REFORM. The Society is currently participating in three separate forums concerning tort reform--both governmental and nongovernmental. RIMS will also continue to present its case through the political process. Pre-election breakfasts have been conducted with the candidates for governor and lieutenant governor.

- PUBLIC SERVICES. In an effort to provide public information on quality, affordable health care, RIMS through an advertisement in the Providence Journal Bulletin is urging patients to discuss the various insurance plans with their doctors. This effort also includes a brochure published by the Society comparing several plans. Additional public service activities will be undertaken.

- DISSEMINATION OF INFORMATION. A new format for a newsletter is under consideration to provide members with more timely news. The current format requires between three and four weeks for publication.

Clarisse concluded his address by emphasizing that the changing role of the Society can be only maintained through the support of the entire RIMS membership.

CONSTITUTIONAL AMENDMENT FOURTEEN

The proposed state constitutional Amendment Fourteen was the subject of debate by the RIMS House of Delegates on September 25. The House overwhelmingly voted aginst the amendment and issued the following statement:

> RIMS opposes any attempts by the government to dictate to the physicians what may and may not be done in the best interest of the patient. We oppose this amendment.

The objection of the Society is based on potential governmental intervention into a wide range of medical practices. "As physicians, we feel that Amendment Fourteen would interfere with our ability adequately to counsel and treat our patients," said RIMS President Peter D. T. Clarisse, MD.

The amendment would place legal restrictions, by state authority, on the use of "living wills", durable power of attorney, and the discontinuation of life support systems or other life-extending measures for people who have terminal, irreversible disease.

This amendment is one of fourteen scheduled to appear on the ballot in November.

DELEGATES APPROVE POLICY POSITIONS

The following policy positions were approved at the September 25 House of Delegates meeting:

Medical Discipline

RIMS believes in strong and effective measures to maintain an adequate standard of medical care. To accomplish this we have established programs to address three categories of physicians involved in the delivery of substandard medical care.

- SICKNESS. The Impaired Physicians Committee deals with illnesses such as alcoholism, drug addiction, and organic brain syndrome. This program has been effective for 7 years. The dual objectives are rehabilitation of the physicians and protection of the public. Our success rate in addictive diseases is over 80 per cent. Physicians who do not cooperate with the program are turned over promptly to the newly created Board of Medical Licensure and Discipline.

- INCOMPETENCE. Physicians who unknowingly practice below the acceptable level of competence because of isolation, lack of continuing education, or other causes are referred to the Competency Committee. The objective is to elevate the quality of the care through education of the physician. This committee is active and accepting referrals from any person or organization. Physicians who do not cooperate are referred promptly to the Board of Medical Licensure and Discipline.

- ETHICAL ISSUES. Physicians who knowingly practice below minimal acceptable standards or unknowingly violate ethical principles are referred to the Mediation Committee. Some problems are resolved by peer pressure. If the law has been violated, the matter is referred forthwith to the proper governmental agency (Board of Medical Licensure and Discipline and Attorney General).

In each of the above situations the public is well served at no cost. A strong and effective Board of Medical Licensure and Discipline is essential to deal with criminals and those who do not cooperate with the above programs.

For Profit Medicine

RIMS has no objection to "for profit" entities providing health care so long as they do not interfere with the professional judgement of the treating physician or increase the cost of medical care.

Malpractice Reform

RIMS supports strong and effective tort reform including a limit on awards for non-economic injury and a progressive cap on attorney's contingency fees.

RIMS supports the bills passed in 1986, but believes they are not strong enough to

remedy the malpractice crisis. We believe that the presence of a plaintiff's attorney on the new Board will be counterproductive because of a conflict of interest resulting in less spontaneous flow of information to the Board from the medical community.

The Union

RIMS believes in collective action by physicians which is in concert with state and federal law.. We believe that RIMS has undertaken, is undertaking, and will undertake all legally permissible action to advance the quality of medical care and the welfare of its members. There is no need to duplicate any of these actions.

Mandatory Medical Acceptance

RIMS is opposed to any law mandating acceptance of Medicare-determined fees as total payment for all patients. We advocate acceptance of these fees as payment in full for financially needy senior citizens.

Treatment of Disease by Para-Professionals

The law defines the practice of medicine as the diagnosis and treatment of disease. Penalties are provided for violations. RIMS agrees with this law and believes that the public is best protected by allowing only the most qualified to practice medicine.

Access to Medical Records

RIMS believes that patients should have access to the information in their medical records under the guidance of the attending physician. Medical records should be transferred promptly to other physicians upon written request of the patient.

Mandated Insurance Coverage for Alcoholism and Substance Abuse

RIMS favors the right of the treating physician to choose the most appropriate therapy for the patient. The diseases are widespread and account for a significant percentage of the health-care dollar. Effective treatment of the primary disease of chemical dependence is cost-effective as it reduces expensive medical complications. Inpatient treatment is necessary for some patients and should be paid for by insurance. We favor mandated coverage.

Licensure

RIMS believes that licensure of professionals should be based only on professional qualifications and good moral character.

JUSTICE DEPARTMENT INVESTIGATION OF "PRUDENT BUYER POLICY"

The US Department of Justice has stepped up its investigation of the "Prudent Buyer Policy" of Blue Cross and Blue Shield of Rhode Island (BC/BS). US Attorney Lincoln Almond indicated that the Department has conducted a "preliminary investigation", and its findings now merit a "formal investigation" by the Department's Anti-Trust Division. Under this "formal investigation" records obtained through "demand letters", similar to subpoenas, will be examined closely to determine what impact the BC/BS "Prudent Buyer Policy" will have on the Rhode Island market.

Steven Kramer, an attorney with the Anti-Trust Division, confirmed that the investigation is continuing. Kramer noted that the investigation is proceeding slowly, and currently there are no plans to restrain the Blues from implementing their new plan on November 1 as scheduled.

The new plan is a result of an announcement by BC/BS to amend all participating contracts. The change in the contracts to include the "Prudent Buyer Policy" will alter significantly current payment practices.

The plan is based on two policy statements approved by BC/BS. First, the plan will not pay a provider more for a service, procedure, or product than that provider is accepting as payment in full from any other buyer. Second, the plan will not offer to any provider a payment mechanism which is more favorable than any arrangement which that provider has entered into with any other buyer.

MORE ON MALPRACTICE REFORM

RIMS is participating in three new organizations dedicated to alleviating the liability crunch. Governor Edward DiPrete has established a liability commission to recommend legislative solutions prior to the convening of the General Assembly in January. RIMS President Peter D.T. Clarisse, MD, has been appointed by the Governor to represent the interest of physicians on the commission.

As part of the tort reform package passed by the General Assembly in 1986, a legislative commission was authorized to study malpractice insurance and its effects upon health-care costs in Rhode Island. RIMS President-Elect Richard G. Bertini is serving on the commission.

A third group looking into the crisis is a coalition on liability reform. Included with RIMS in this coalition are the Rhode Island League of Cities and Towns, the Rhode Island Federation of Chambers of Commerce, other business groups, and the Hospital Association of Rhode Island.

JUA SURCHARGE

In a report to the House of Delegates, RIMS legal counsel John Reid III indicated that the suit against the Department of Business Regulation (DBR) appears to be close to a favorable resolution. After initially winning a temporary stay earlier this year, RIMS filed suit against the DBR to block permanently a proposed 16 2/3 per cent surcharge on all medical malpractice premiums. The increase was ordered by the DBR in an effort to bolster the stabilization fund of the Joint Underwriting Association (JUA).

Reid noted that RIMS briefs have been filed in the case along with the following document. In response to a point raised by the DBR questioning the Society's standing, an affidavit based on a survey of the members of the Council has been submitted. The affidavit shows standing by establishing that the great majority of RIMS members are insured through the JUA.

AAMSE REPORT

Bruce Balfe of the AMA will be in Providence, Rhode Island during October for a special meeting with the Council concerning the report on RIMS of the American Association of Medical Society Executives (AAMSE). During this two-day session the Council will consider the AAMSE recommendations in determining long-range plans for the Society.

A review team from AAMSE visited with the Executive Committee and RIMS staff this past summer. Their findings were forwarded to the Society in August. Identified as the number one concern is a need for stated long-term goals and priorities. Also addressed were the Society's physical assets, publications, alternatives to the Joint Underwriting Association (JUA), and the Rhode Island Medical Political Action Committee (RIMPAC).

PARLIAMENTARIAN APPOINTED

At the September 25 RIMS House of Delegates meeting, President Peter D. T. Clarisse, MD, announced the appointment of Louis Fuchs, MD, as parliamentarian of the Society. The parliamentarian is responsible for determining that the conduct of the Society adheres to its parliamentary rules.

RIMS ANNUAL MEETING DINNER/DANCE

The dinner/dance associated with the annual meeting of the Society will be held at the Rosecliff Mansion in Newport, Rhode Island. This event is scheduled for Friday, May 15, 1987. Further details will be published as they become available.

DELTA DENTAL NOT OFFERED

At the October 6 RIMS Council meeting it was announced that the Delta Dental Insurance plan will not be offered to RIMS members. This action is the result of inadequate response on the part of Society members.

Rhode Island Medical Journal

October 1986
Volume 69, Number 10

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COVER:

A volunteer answers a telephone call from an anxious teenager. The Samaritans of Providence, Rhode Island are dedicated to helping the lonely, desperate, and suicidal 24 hours a day.

Photograph by Scott Robinson, Providence, Rhode Island.

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EDITORIAL

Suicide in the Adolescent Population

In the quarter-century between 1960 and 1985, an estimated 645,000 Americans have committed suicide, accounting, on average, for about three deaths each hour. In 1960, the suicide rate was 10.6 per hundred thousand population. It rose in 1970 to 11.6 and peaked at 12.5 in 1980; since then it has stabilized or even declined slightly.

These statistics for the general population obscure certain more compelling trends in particular subgroups. The suicide rate for elderly persons, historically the age group most vulnerable to acts of self-destruction, has been decreasing of late while the rates for individuals in the 15-24 year range has increased. This is most conspicuously evident among white males where the suicide rates between 1970 and 1980 have increased by 60 per cent in the 15-19 age group and 44 per cent in the 20-24 age group. Indeed, suicide among white males, ages 15-39 years, now accounts for more than one-third of all suicide deaths in the United States. These recent trends in the rates of suicide have paralleled the even more disturbing increases in homicide rates. In contrast, general accident mortality rates have diminished during this time interval.

The problem of suicide among teenagers must not be ignored. Each year among every hundred thousand young people there are more than twelve who take their own lives, and another 130 who attempt suicide unsuccessfully. For a variety of social, actuarial, and professional reasons there is a consistent underreporting of suicide in the United States. Indeed, one team of investigators has recently reported the alarming observation that almost nine per cent of adolescents have made at least one suicide attempt. Suicide is now the second leading cause of death of white teenagers in the United States.

In 1985 the state of Rhode Island created a Task Force on Teenage Suicide Prevention with members derived from the state legislature; the Office of the Medical Examiner; the Department of Health; and the medical, social work, and teaching professions, as well as certain concerned citizens. The Commission is co-chaired by Mrs. Carolyn B. Drew, Executive Director of the Samaritans and Richard Licht, Lieutenant Governor of Rhode Island.

This issue of the *Journal* is devoted in its entirety to the forensic, preventive, epidemiologic, and clinical features of teenage suicide. Mrs. Drew and her associates at the Samaritans provide an assessment of a pilot suicide awareness, identification, and prevention program recently conducted in selected public high schools in Rhode Island. The study is funded by a grant from the National Conference of State Legislatures.

Doctor William Q. Sturner, Chief Medical Examiner of the state, offers a paper which summarizes the experiences of his office concerning adolescent suicide during the past decade. There has been a disturbing nationwide increase in the percentage of suicides accomplished with firearms, reaching about 57 per cent of all self-in-

flicted deaths in recent years. These suicides employ a method which is immediately lethal and which precludes the possibility of rescue or reversibility, in contrast, for example, to poisoning. Sturner's data indicate that Rhode Island is not following a national trend in this regard.

Dr. Lewis Lipsitt, Professor of Psychology at Brown University, discusses his experiences and hypotheses concerning suicide attempts in adolescence. Doctor Andrew Slaby, Professor of Psychiatry at Brown University and Psychiatrist-in-Chief at the Rhode Island Hospital, describes strategies for the prevention, early identification, and management of the suicide-potential teenager. Doctor Slaby emphasizes particularly the role of the non-psychiatrist physician in recognizing and preventing this potential tragedy. His paper provides us with the sobering observation that almost three-fourths of all teenagers who have died by suicide have been seen by a practicing physician within four months of the fatal event. There is every indication that suicides, particularly those among adolescents, are not a randomly distributed phenomenon. We know that they occur consistently in males more than females and in whites more than non-whites. Other recent studies provide us with hints that such distant events as respiratory distress at birth, a lack of antenatal care before the twentieth week of pregnancy, and chronic disease of the mother during pregnancy which may increase the risk of suicide when the infant grows into adolescence.

The goal of the many efforts described in this issue of the *Journal* is, first, the identification of those individuals who are uniquely at greater risk for suicide during adolescence and second, the investment of the limited resources of the state in trying to prevent suicide through selective education and counseling.

Stanley M. Aronson, MD

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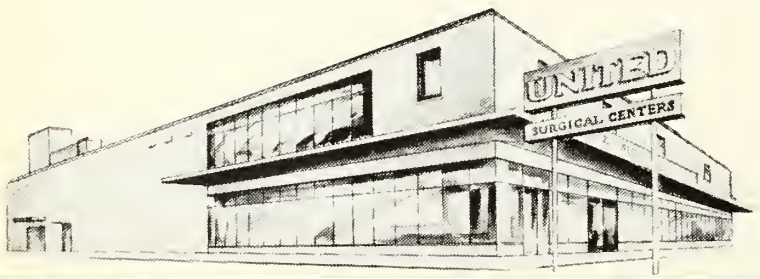
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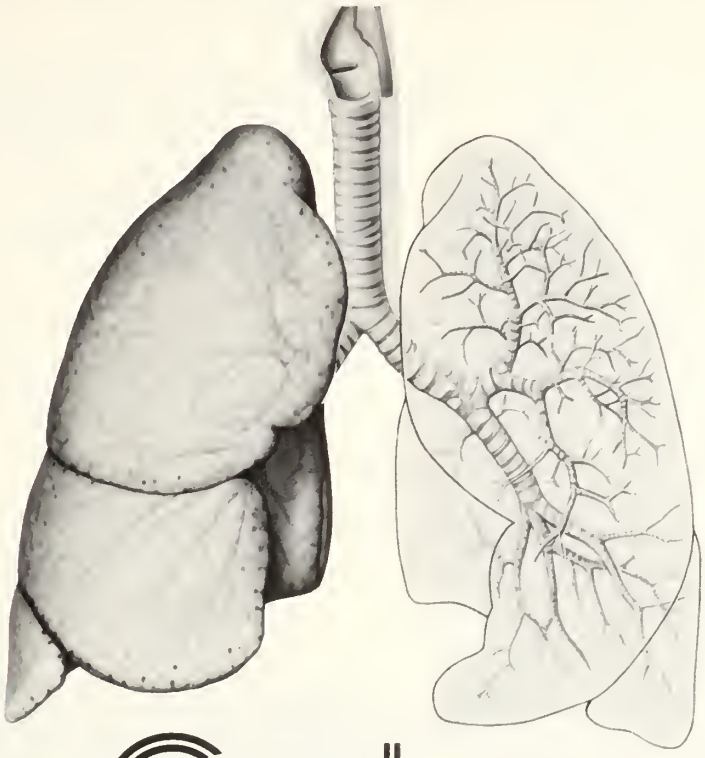
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- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
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- Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy
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PRESIDENT'S PAGE

Together We Will Make a Difference — Back RIMPAC



Peter D. T. Clarisse, MD

The November 4 general election is drawing near. Voting is one way of having an impact on the outcome. However, there is another very important medium through which physicians can be involved. That is by participating in the Rhode Island Medical Political Action Committee — RIMPAC.

In today's environment PACs are an important part of the political process. And in our profession we cannot afford to ignore their importance. The practice of medicine is a highly regulated occupation. The candidates elected this November will help shape the manner in which you and I practice medicine.

During the past session of the General Assembly more than one hundred bills potentially affecting the practice of medicine were introduced. Malpractice reform and mandatory Medicare assignment were among the most controversial measures proposed. No less than six bills were introduced that in one way or another would have forced physicians to accept Medicare assignment. Also, there are legislators who would like to grant to patients absolute access to their medical records. Others would make the records of medical peer review committees discoverable in litigation.

It is obvious that in this climate we cannot sit idly by. We won some battles in 1986, but be assured that we have not seen the last of these issues. They will reemerge next session, and the following session, and the one after that. The days are fast disappearing when you can leave everything to a single lobbyist. We must become a more effective force in the political arena of the state. It is important that candidates who understand and appreciate the role of physicians, as well as of the health care industry, be elected.

Just as we need the support of our public officials during the legislative session, while campaigning they must have the support of the medical community. We have in place the apparatus to provide this assistance, but it is weak. It must be strengthened. If we are to increase our political clout and elect those candidates who respect our positions, we must beef up RIMPAC, not just in dollars, but also in the number of Rhode Island physicians who participate.

In Rhode Island with a highly sophisticated Society membership, it is disappointing that RIMPAC support comes from less than 10 per cent of our members. This lack of enthusiasm sends the wrong message to our legislators. We must convey to them that physicians are concerned about legislation and regulations that affect the quality of health care. Our message will be heard if we support our political action committee.

Individually, physicians cannot be very influential. Together, Rhode Island doctors can challenge the ever-alert special interest groups with their substantial war chests.

I urge every one of you to increase the level of your political activity. We have a responsibility to our patients and to our profession. The Society must assume a leadership role in politics. Expanding our support for RIMPAC is one way that Rhode Island doctors can meet this challenge.

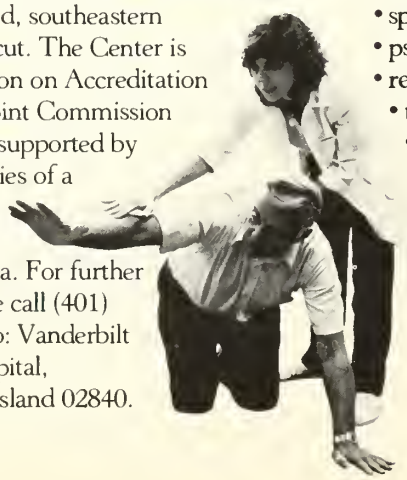


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A Pilot Suicidal Awareness, Identification, and Prevention Program

Educational Program in Area High Schools Demonstrates Effectiveness in Preventing Suicides

Sally Ashworth
Anthony Spirito, PhD
Albert Colella, PhD
Carolyn Benedict Drew

Many believe that education of high school students in the classroom is a useful and effective tool in suicide awareness and prevention. Systematic program evaluation of such projects, however, has often been lacking. This paper describes the training curriculum for a pilot suicide awareness project and the measures used to assess effectiveness.

Through the Rhode Island Task Force on Teenage Suicide Prevention, the Samaritans of Providence, Rhode Island received a grant given by the National Conference of State Legislatures to conduct a pilot program on suicide prevention in public schools in Rhode Island. The primary objectives of the study were: (1) to provide a timely, accurate, and quantitative assessment of an already developed and published methodology for suicidal awareness, identification, and prevention; (2) to report findings back to the Rhode Island Teenage Suicide Task Force and to make recommendations to that body and the Rhode Island legislature of study findings; and (3) to provide, nationally, to the legislative and educational communities, a proven methodology, program, and documentation that are adaptable to state, regional, city, and town needs.

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Method

Setting: The research was conducted in eight Rhode Island high schools. Two urban, two suburban, two suburban/rural, and two rural schools participated, with one school in each category receiving the suicidal awareness/prevention program and the other four schools serving as matched controls. All schools volunteered to participate.

Subjects: All ninth grade health teachers (n = 9) in the four program schools were trained and implemented the program in their classrooms. A total of 613 students (231 urban, 186 suburban, 86 suburban/rural, and 110 rural) were involved. Control schools had 53, 92, 281, and 321 students respectively for a total of 747.

Teacher training: Teachers were trained in a two-day session conducted by the Rhode Island Suicide Prevention Center, a program of the Samaritans of Rhode Island. Training included attitude and value awareness, statistics about teen suicide, suicide risk factors, recognition of at-risk students, referral concerns, and practical suggestions for implementing the suicide prevention curriculum in the classroom. During the workshop, a teacher's manual, written by a teacher from the Samaritans, was distributed for use in the program.

Suicide curriculum: Teachers implemented the six-lesson structured curriculum developed by the Samaritans. Content included attitude, awareness, facts about adolescent suicide, risk factors, and identification, intervention, and referral

techniques that students themselves could use with peers at risk. Teachers also conducted less structured discussion sessions to explore feelings and attitudes about adolescent problems, suicide, and death.

Measures: The following variables and accompanying measures were selected to evaluate the impact of the program on teachers and students. All measures were administered at similar intervals to program and control schools.

Knowledge: A 33-item true-false Knowledge Questionnaire was developed and administered before and after the course to determine if participation resulted in increases in factual information regarding adolescent suicide. Sample items include "the teenage suicide rate has tripled over the past 25 years" and "most suicides occur without any warning signs or clues." Some items were taken from measures used to evaluate similar programs, and some were devised to reflect the specific information contained in the program. Parallel versions for teachers and students were developed.

Attitudes: Attitude change in teachers was assessed before and after the course using a Teacher Attitude Scale in five-point Likert format ("strongly agree" to "strongly disagree"). Same items include "most teenage suicide threats are just attention getting" and "as a teacher, one should be willing to discuss a student's feelings about killing himself/herself." A thirteenth item listed five feelings that could be provoked by encountering a student who is threatening suicide (eg, pity, anger, anxiety) and asked teachers to assess their own feelings on a scale from "definitely yes" to "definitely no." This scale was used to measure attitudes, beliefs, and feelings about suicide and death.

Student attitude change was measured with a parallel scale. The first ten items were identical to the Teacher Attitude Scale, and an eleventh item paralleled the "feeling" item of the teacher scale, asking students to rate from "definitely yes" to "definitely no" six feelings they might experience if a friend threatened suicide.

Helping behaviors: The Teacher Personal Knowledge Form and the Student Personal Knowledge Form were developed for this study in part to estimate the frequency of certain helping behaviors before and after the intervention. At pretest, students and teachers indicated how often they had performed certain helping behaviors (eg, trying to talk to a student contemplating suicide; referring a student for services) last year. At posttest, they rated how often they had performed these behaviors in the current year.

In addition, the Teacher Workshop Evaluation and the Student Course Evaluation, described below, each contained some items indicating the intention to perform certain helping behaviors. Items included "I am now likely to ask a student if he/she is contemplating suicide" and "I am now likely to help a student," rated on a scale from "much less likely" to "much more likely."

Counselor referrals: A Counselor Referral Form was also devised to permit uniform tracking of suicide-related incidents and referrals at each school. Guidance counselors at all schools agreed to use the form, which requires the counselor to categorize each incident (attempt, gesture, threat, or ideation) and describe intervention and referral details.

Student "hopelessness": Since a feeling of hopelessness often accompanies adolescent depression and may be a precursor or at least a concomitant of adolescent suicide, a standardized Hopelessness Scale (Kazdin et al, 1982) was administered before and after the program. The scale contains 17 true-false items. Previous research on a sample of child psychiatric patients demonstrated adequate reliability (coefficient = .75; Spearman-Brown = .70). The validity of the measure was suggested by a significant correlation with a measure of depression ($r = .49$) and a negative correlation with a measure of self-esteem ($r = -.54$). Hopelessness was assessed as a way to examine the possibility that the suicide awareness curriculum had an adverse effect on emotional status.

In addition, the Teacher and Student Personal Knowledge Forms explained above had items which attempted to estimate rates of suicidal behavior before and after the intervention. At pretest, teachers and students were asked how many students they know of last year who attempted suicide, or who spoke openly of committing suicide. At posttest, they were asked how many they knew of this school year.

Consumer satisfaction: A Teacher Workshop Evaluation form and a Student Course Evaluation form were devised and administered to assess consumer acceptance and perceived value of the program. Each was an identical 13-item rating scale which measured satisfaction with various aspects of the program and also measured state intentions to perform various helping behaviors. Teachers completed the questionnaire at the end of the pre-program training and students when the classroom curriculum was completed.

Preliminary Results

Below are reported the baseline evaluation results for four of the assessment measures discussed previously. Although we have designed a pre-post control group study, long-term results are considered the most important that could be garnered from this project. Other projects have assessed change immediately following the intervention. One would certainly hope that change would occur on such short-term follow-up. Of much more practical significance seems to be the long-term followup which occurs with any program. Consequently, it was decided that the most important follow-up data would be that which could be collected toward the end of the school year.Thus, for this preliminary report, we shall be presenting only the pre-test data on our assessment measures. These pre-test attitudes provide us with some understanding regarding naturally-occurring attitudes and knowledge on the topic of suicide among adolescents. Thus, even these preliminary data provide important information for public policy, and we hope that these preliminary results can be utilized in such a fashion.

The percentage of items that were correct on the Knowledge Test for each school was calculated. The percentage of correct items ranged from 59 to 73 per cent with an average somewhere about 66 per cent. There were some differences across the four geographically related schools, but the average percentage that were correct by each of the four geographic categories was in the 60 per cent range with very few differences between the schools. Considering the fact that 50 per cent of correct items would be expected by chance using a true-false format, this seems a rather low level of knowledge for these students.

The data collected on Student Attitudes regarding suicide were also interesting. For example, one of the questions read as follows: "A friend of yours tells you that he/she is thinking about committing suicide." A five-point scale, ranging from one (uncomfortable) to five (comfortable), was used in an attempt to gauge students' feelings about this situation. The average responses of students on these particular items was "unsure," since their mean scores were very close to three,which was the unsure response. As with the results of the Knowledge Test, these Student Attitude results are noteworthy for the fact that there seems to be few differences among the schools by geographic area on their attitude toward this difficult situation.

The Student Personal Knowledge form asked questions regarding aspects of suicide. The first two questions focus on the incidence of suicide attempts as known to each student. These questions were employed as a way to get some natural survey of the incidence of this problem in our state. The results indicated that ninth grade students have contact, on the average, with two to three peers who spoke of attempting suicide. The idea that a student would be placed potentially in the situation of responding to such behavior two to three times even before the midpoint of their ninth grade school year speaks to the importance of providing these students with some reasonable guidelines on how to act in such situations. The last three questions on this measure assess helping behaviors reported by these students. Of interest here in particular is the quite high score on the number of peers consoled, and the comparatively low number of peers referred for professional help. The average student spoke to about four peers who expressed suicidal intentions, but referred only one student on average for professional help. These data suggest that in fact a relatively large peer support network for adolescents with suicidal ideation exists naturally in our school system. Since these are untrained counselors, being able to provide such students with information and knowledge regarding suicide would appear to be a very important preventative effort.

Table 1 presents preliminary results of the scores obtained on the Hopelessness Scale. This is a 17-item scale, so that the mean scores, which fall below 6.2, are in the bottom third of the scale. Higher scores indicate higher levels of hopelessness. There seem to be some differences among the schools according to geographic areas, but whether these are of practical significance is questionable. Since the Hopelessness Scale does not have norms, comparison to such data is not possible. However, in comparing the scores from this population to those obtained by 40 adolescent suicide attempters who have been admitted to Rhode Island Hospital in the past year-and-a-half, mean scores fall below the typical range of scores obtained by this population (range 7 to 11). The baseline scores are of sufficient magnitude to allow for change to be assessed over time whether an intervention is introduced or not.

Pre-test-Post-test Results

At the time of the writing of this report, only some of the post-test data were available from

the experimental schools. Thus we are able to comment in a limited fashion on the results of the program, but definitive findings will await the collection of data at the control schools and statistical analysis.

Post-test results were available on the Suicide Knowledge Test for three of the experimental schools: suburban, suburban/rural, and rural. The findings show quite substantial gains in knowledge by those students who participated in the suicide intervention program. Students gained 7 to 9 points on the average from pre-test to post-test. By the post-test assessment point, teenagers in the suburban school increased their percentage of correct items on the Knowledge Tests from 67 per cent to 85 per cent. In the suburban/rural schools, the percentage increased from 59 per cent to 84 per cent. And finally, in the rural school, the average percentage correct increased from 72 per cent to 89 per cent. These are rather impressive gains in knowledge regarding suicide for each of the three schools. In addition, the overall percentage of correct items which was in the upper end of the 80 per cent range was also quite respectable. Thus, it would certainly appear that in the course of the year students who participated in the suicide intervention curriculum become much more knowledgeable regarding this issue. Whether this increase in suicide knowledge was a direct result of the curriculum or of other factors will not be known until we can compare the results of these schools with those in the control schools.

The results on the Hopelessness Scale were available for three of the school districts: urban, suburban, and rural. These results are represented in Table 2. As can be seen from this table, all three schools showed decreases in the level of hopelessness exhibited by their students over the course of the few months following the implementation of the suicide curriculum. The changes which occurred were statistically significant although, once again, whether they are a direct result of the suicide prevention curriculum or other factors cannot be answered until we compare the results with the control schools. However, the consistency of positive change across the three schools is certainly encouraging.

Impressions

The primary purpose of the Samaritans of Rhode Island is to be available to the lonely, depressed, and suicidal 24 hours a day. During 1985, 111 volunteers gave more than 26,000 hours to answer 51,000 calls. Eighteen per cent of the calls in 1985 were from young people between the ages of 10 and 19. The secondary purpose of the Samaritans is to inform and educate the Rhode Island community about suicide prevention. Through the information gleaned from the study, the Samaritans hope to improve upon their adolescent suicide prevention program.

Initial subjective findings suggest that the program does lead to behavior change. Both teachers and students reported an increase in helping behaviors. During this time, third party calls to the Samaritans increased by 84 per cent. Evaluations by students, teachers, and parents were very positive and supportive. The post-test data and hopelessness and knowledge is also quite promising.

Consequently, a collaborative effort of the Rhode Island Department of Education, the Rhode Island Department of Health, the Rhode Island Task Force on Teenage Suicide Prevention, and the Samaritans has been made to insure the future of the suicide awareness program in Rhode Island. The following steps have been taken:

(1) The Rhode Island Department of Health has provided the Samaritans with a three-year step-down grant to implement the program with teachers.
(2) The Department of Education has incorporated suicide prevention into the mandatory health curriculum.
(3) The Task Force is coordinating department heads in their efforts to implement statewide programs. A bill has been submitted to the 1986 General Assembly for a suicide awareness program for public school students in grades 9-12, accompanied by workshops developed and provided by the Samaritans for those public school teachers who are designated to teach the suicide awareness program. In addition, plans are under way for a statewide conference on teen suicide in the winter of 1987.
(4) The Samaritans will coordinate a graduate-level course on suicide prevention education at Rhode Island College starting in the spring of 1987.

Table 1. — Hopelessness Test Results*

	Mean	Standard Deviation
Urban		
Experimental	5.1	2.0
Control	3.9	1.3
Suburban		
Experimental	4.2	0.7
Control	4.9	1.7
Suburban/Rural		
Experimental	6.2	1.3
Control	4.4	0.5
Rural		
Experimental	5.4	2.2
Control	5.2	1.8

* Higher score indicates greater hopelessness.

Table 2. — Hopelessness Test Results — Experimental Schools

	PRETEST		POST TEST	
	Mean	Standard Deviation	Mean	Standard Deviation
Urban	5.1	2.0	2.5	0.4
Suburban	4.2	0.7	3.6	0.4
Rural	5.4	2.2	2.9	1.5

* Note: Lower score indicates less hopelessness

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Prevention, Early Identification, and Management of Adolescent Suicidal Behavior

Reduction of Adolescent Suicide Attempts and Completion Requires a Program of Primary, Secondary, and Tertiary Prevention

Andrew E. Slaby, MD, PhD, MPH

These graves are all too young, from the world's bitter wind seek shelter in the shadow of the tomb. — Percy Bysshe Shelley

Not that suicide always comes from madness. There are said to be occasions when a wise man takes the course, but, generally speaking, it is not in an access of reasonableness that people kill themselves. — *Collected Letters,* Voltaire

Rates of suicide and parasuicide (attempts) have increased dramatically in the last few decades. Increases are most dramatic among our youth.[1-3] One percent of all individuals die by suicide,[4, 5] with approximately 27,000 killing themselves each year.[1, 6] Two decades ago, risk increased with age. Now risk peaks in adolescence and the later years. There has been a 250 per cent increase in rates in the 15-24 year-old range over twenty years rising from 6.8/100,000 to 17.4/100,000. The rate of 20-24 year-olds is not again attained until age 55.[2] While suicide is rare although not unheard of prior to puberty, it is second only to accidents as a cause of death in adolescents.[7] Accidents, especially vehicular accidents, in addition are a common cause of occult suicide.[1, 2] Experts estimate that the true figure for completed suicide is at least three times that reported.[8, 9] Exclusionary causes in insurance, taboos, and impact on relatives limit more complete disclosure.[10]

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Suicide is a major public health problem and therefore must be attacked using the classic paradigm of primary, secondary, and tertiary preventive interventions. Success in application of this model entails thorough understanding of the scope of the problem, its risk factors, its putative causes, its clinical signs and symptoms, and the impact of intervention and treatment.

Risk Factors for Adolescent Suicide

Characteristics of suicide and parasuicide are provided in Table 1. Remarkable in the contrast is that those who commit suicide (as opposed to those who attempt) are more frequently male; have fewer obvious problems with parents, siblings, and friends; are successful at school; are less disordered in character; attempt in private; and have communicated their desire to die to someone before the act.

The median age of suicide attempts and completions has fallen from 47.2 years in 1970 to 39.9 years in 1980, with the decline greater for males than females. In 1980, more than one-third male suicides were under 30 years of age. Characteristics of suicide attempters and completers across age categories, on the whole, share two components critical to prevention and management: social isolation and clinical indicia of psychiatric illness.[1, 3, 5, 11, 12, 14] There are exceptions at all ages. Unfortunately, exceptions are greater for the young than the aged. Saint Augustine[12] saw a need for moral strictures to prevent over-zealous early Christians from self-destruction as evidence of their newly-emerged belief in afterlife. Without promise of heaven, Marcel Proust imparted the idea that the only thing that got him through a difficult day was

Table 1. Characteristics of Suicide and Parasuicide[11-15]

Completers	Attempters
More males	More females
More major psychiatric disorders (e.g., depression, alcoholism, and schizophrenia)	More character disorders (e.g., antisocial and borderline personality)
More family histories of mental illness	Make attempts impulsively
Give warnings	More public about attempts
More frequently have experienced suicide in a family member or peer	Tend to use less lethal means (e.g., overdose)
Make attempts in secret	More obvious problems with parents, siblings, and peers
More intelligent	Poor academic performance
Use more lethal means (e.g., guns, hanging, jumping)	Over-representation of Protestants
Fewer obvious problems with parents, siblings, and peers	
Previous suicide attempts	
Successful at school	
Over-representation of Protestants	

the comforting thought of suicide. Adolescents are impulsive and romaticize premature exodus from life as did some early Christians and people such as Proust. They lack the wisdom of age, the acute learned awareness of the permanence of disability and death, and the mollification of impulsiveness that comes with responsibility, children, and property. In a world fraught with disappointment, human love is a recurring reward and reality to those who have lived long enough to experience the consistency of the theme. Not every young person stating a wish to end his or her life intends to do so. Some are communicating a message. Unfortunately, messages are not always heard. The intensity of the message may be greater than that intended consciously or unconsciously and lead to unexpected death or permanent impairment (eg, brain damage).

Adolescent suicide completers, when contrasted to controls or attempters, are characterized by a tendency to be very successful at school, of superior intelligence, and be male and white. They are described as solitary and as frequently having histories of mental illness in their families and experience with suicidal behavior in family members and peers. A key to prevention is the fact that many have attempted prior to the act and most communicate their desire to die.[1-3, 6, 11, 12, 16-18] The message is sometimes given to the primary care physician or therapist, but more often to a family member or friend.

Fifty to ninety per cent of those who complete suicide suffer mental disorder, most frequently depression, alcoholism, and schizophrenia.[11, 19] Violent means such as guns are most frequently used by male completers and increasingly used by female completers.[12] While hospitalized and discharged psychiatric patients are at increased risk for suicide,[5, 20-26] the hospitalized physically ill are less so. When the latter do, they generally have severely painful chronic illness or organic mental syndromes.[27, 28] The immediate post-psychiatric discharge period is a time of greater risk, especially if an adverse life event is experienced, such as school failure, parental divorce, or the end of a love affair.[5] College students are at higher risk than non-academic peers.[29, 30] Rates are particularly great for those at elite competitive colleges.[2, 3, 31-35] Some adolescents sent off to boarding school before college are at increased risk because of other factors that enhance risks such as parental separation or lack of parental interest.[36]

Unlike married adults, married adolescent girls are at greater risk than single peers.[30] Teenage suicides, in contrast to adult suicides and teenage auto fatalities, are not influenced by temporal variables.[37] No biological markers have been identified in a practical way to facilitate identification of those at risk.[2]

Risk Factors for Adolescent Parasuicide

Attempters differ from completers and controls by greater use of drugs as a means; more frequently being female; having more problems with relationships with parents, siblings, and friends; failing in school work or having dropped out; having histories of involvement with social services; and more frequently being involved in psychiatric treatment at the time of the attempt. Adolescent attempters report more gastrointestinal complaints and are more frequently pregnant than controls. Fathers are more frequently absent and nonemployed, and mothers more fre-

quently working outside the home. Nonpsychotic psychiatric illness (eg, character disorders, alcoholism, and drug use) is more common among attempters than among matched controls. Depressive symptoms are of much greater frequency than actual depression.[19] There is often a family history of suicide or suicide attempt (seven times that of controls in the study of Garfinkel and Golombek).[12]

Most adolescents who attempt do not go on to kill themselves, but the majority of those who do commit suicide have attempted.[11] The number of attempters is much greater than completers, providing the basis for the misconception that those who attempt do not go on to kill themselves.

Children who attempt exhibit greater physical health impairment. They also experience more early parental loss due to death, divorce, or separation; more abuse from parents; more dominant fathers when present; and parents (particularly fathers) who have chronic physical or mental illness, or have attempted or completed suicide.

Attempters are more frequently of lower socioeconomic and urban status. Puerto Rican children currently have (and black children in the past when they first moved to urban areas had) higher rates due to lack of acculturation.[7] Drug and alcohol abuse provides a substrate for suicidal ideation and attempt.[11, 19, 38] Attempters are more frequently born to unwed mothers and are rejected by their parents. Interestingly, young women (aged 18 to 30) have been found in one study to be less hysterical than controls immediately after drug overdose. This may be due to the fact that acting out temporarily mollifies hysterical traits. The family life of attempters is characterized as less warm.

Attempters are comparable to completers in frequently having made previous attempts. Suicidal children are frequently intensely aggressive and have histories of parental assault.[2, 5, 7, 11, 12, 16, 17, 19, 22-24, 26, 29, 40] Attempts are highest in autumn and winter and between 6:00 pm and midnight.[12, 16]

Neuringer and Leitter[17] reported that, despite the fact that 88 per cent of attempts of a population they studied occurred at home (usually with a parent in another room), only 46 per cent of adolescents reported the attempt to their parents. Two-thirds reported it to someone other than their parents, such as a peer whom they trusted. It is important to recall that adolescents, like adults, indulge in self-destructive sexual behavior such as autoerotic hangings and bondage that, while not directly intended, can lead to death. Therefore such behavior must be construed as a risk factor.[41]

Table 2. Signs and Symptoms of Adolescent Suicidal Potential

Aggression
Depression
Excessive guilt
Giving away prized possessions
Helplessness
Hopelessness
Hypersensitivity
Impulsivity
Isolation
Low frustration tolerance
Low self-esteem
Psychomotor retardation
Risk-taking behavior
Sadness
Sleep disturbance
Substance abuse
Suicidal ideation
Unusual neglect of appearance
Withdrawal
Worthlessness

Indications of Suicidal Potential

Signs and symptoms of adolescent suicidal potential are portrayed in Table 2. In summary, they include indications of depression (eg, hopelessness, sleep disturbance) coupled with a tendency toward impulsive behavior.[18]

Clinically, attempters exhibit sadness, isolation, aggression, withdrawn behavior, and depression.[12] Depression, a symptom of affective illness, is also a symptom of other disorders such as schizophrenia.[20] Although there is no generally agreed upon suicidal personality, commonly reported traits include immaturity, egocentricity, dependency, hostility, anxiety, low tolerance to frustration, impulsivity, low self-esteem, and hypersensitivity.[7, 19] Potential attempters often feel different from peers because of physical or psychological unattractiveness or lower intelligence or because parents have foisted upon them adult responsibilities at an early age. They feel overwhelmed and react by becoming suicidal. Youthful attempters as a group exhibit more aggression, hostility, impulsiveness, sadism, and masochism. Suicide modeling appears to be a factor in suicidal children. Many adolescents who

complete suicide have known personally another who has. While girls attempt more, boys are sicker and use more lethal means, such as hanging or shooting. Culturally, girls are not allowed as many aggressive outlets as boys, such as fighting and promiscuity, without more public censure. They are, therefore, more likely to turn hostile feelings inward. Such behavior is likely to result in suicide.[7] Menninger,[42] in his early discussions of addiction, viewed dependence on drugs as a protracted form of suicide. Subsequent studies have confirmed his earlier hypothesis. Both attempters and completers often have histories of substance abuse.

A deliberate self-harm syndrome has been described invoiving sudden irresistable impulses to harm oneself. Onset is typically in late adolescence with multiple recurrent minor self-destructive episodes in response to an intolerable situation which the adolescent cannot escape or control. These individuals report hopelessness, helplessness, worthlessness, and depression. The self-destructive behavior tends to increase in lethality over time, leading in some cases to suicide. Disruption of social supports, drug and alcohol abuse, and depression are risk factors. Pfeffer[24] emphasizes similarity among suicidal behavior of children, adolescents, and adults with depressive and borderline patients at high risk in all age groups.

Motto[43] followed 335 adolescents, ages 10 to 19, known to be at high risk for suicide by virtue of admission to a hospital due to a depression or suicidal state and found that the variables most closely associated with a suicidal outcome include clear communication of intent and actively seeking help in those who made an attempt; fear of losing one's mind or of having a rare disease; over five hours' sleep; psychomotor retardation; moderate ability to communicate feelings of hopelessness; and a negative or mixed attitude toward the interviewer when first seen. In addition to the fact that parental suicide increases the risk a child may kill himself or herself, other pathogenic effects of the emotional context leading to and surrounding parents' suicide have been identified as guilt and distorted communication.[45]

Causes of Adolescent Suicide

Simplistic causes of adolescent suicide are hard to isolate, probably because they rarely or never exist alone. The act entails a number of factors, some of which are provided in Table 3.

While factors may emerge as "reasons" for a particular self-inflicted death, many more individuals with the same characteristics and "reasons" do not kill themselves or even attempt to. This confirms the hypothesis that adolescent suicide is a multidetermined event involving genetic, social, psychological, biological, life-stress, developmental, and existential (ie, no reason to live) factors. Among these factors are escape from family problems; guilt (eg, over being homosexual); lack of acceptance into peer groups; breakdown of the nuclear family; unemployment; failure to make good grades; a desire to be united with someone who has died; and difficulties with parents, siblings, friends, and lovers, [1, 22] Other explanations include *anomie* (a "loss of relatedness"),[46] identification with an absent father,[47] aberrant child-rearing practices,[48, 49] pre- and per-

Table 3. Factors Contributing to Adolescent Suicide

Individual	Environmental
Anomie	Academic stress
Chronic disease	Breakdown of social supports
Desire to be united with someone dead	Breakup of love affair
Existential nihilism	Child rearing practices
Feeling unwanted	Cultural sanctions
Genetic predisposition	Family problems
Guilt	Loss of parent through death, divorce, or separation
Impulsivity	Models of suicide
Loneliness	Peer rejection
Perinatal distress	Sexual abuse
Psychopathology	Unemployment
Revenge	
Secondary gain	
Sexual confusion	

inatal factors such as respiratory distress, lack of antenatal care, chronic disease,[50] incomplete families, several changes of guardians, maltreatment as children, sexual abuse,[25] and incorrect fantasies of reversibility of death.[7]

Suicidal youngsters experience excessive amounts of environmental stress, commencing in early childhood, relating to parental loss through death, divorce, or separation (sometimes due to hospitalization), and experience aggression and suicidal behavior in their parents.[24] Sometimes a cause seems trivial on the surface but represents to an adolescent the "last straw."[7] Medical illness such as hypothyroidism and certain medications cause a negativistic distortion of reality that can lead to self-inflicted death.

A systematic study of 50 adolescents 13 to 18 years old indicate reasons given by subjects for a suicide attempt and those attributed by clinicians differ. Adolescents indicated they felt lonely or unwanted, were angry with someone, or wanted to alleviate stress. Clinicians deemed the overdoses punitive or manipulative and suggested that only seven wished to die. The youths denied overdosing to get help, suggesting that a more appropriate means of prevention entails accent on change of attitudes toward self-poisoning and early help seeking. Children imitate behavior of older children or loved ones who have died by suicide, such as a parent, sibling, or aunt. A young person may romanticize death as reunion. In other instances, revenge appears the motive: "This will fix them."

There is a dangerous misconception that all adolescents who kill themselves are psychiatrically ill. Self-inflicted death is 80-500 times more common among those with serious depressions,[3,36] but many who died by suicide are simply impulsive, angry, lonely, or chronically ill. Many teenagers who indulge in risk-taking behavior, such as driving cars fast or drug experimentation, are without overt depression, making suicide harder to predict and more general programs of prevention necessary.

Stresses for our young people today are increasing, while natural buffers (ie, social supports) are decreasing. More adolescents are vying for the same positions in college, professional schools, graduate schools, and jobs, while the extended and nuclear family, organized religion, and traditional community are disintegrating. This creates the sense of *anomie* and powerlessness that Emile Durkheim[46] in 1897 felt to be the critical factor in many suicides. In support of this contention is the observation[1-3,6] that suicide rates for those over 65 have fallen steadily during the last two decades as the cohort in that age group has increased. Old age was for many a time of loneliness and lack of support or purpose — *anomie*. Now, as more individuals survive to that age group, we see more support, both psychological and financial, for older people. It is a time of life when cohesiveness rather than competitive forces are predominant and essential for survival. Cohesion appears to reduce suicide rates while competition enhances them.

Prevention

Reduction of adolescent suicide attempts and completion entails a program of primary, secondary, and tertiary prevention. Primary prevention involves reduction of the incidence of illness by reduction of the impact of potentially noxious events. Polio vaccine immunizes an individual against the development of polio. Secondary prevention entails early recognition and treatment of illness to prevent long-term disabling effects. Penicillin for streptococcal throat infections reduces the development of rheumatic heart disease and glomerulonephritis. Tertiary prevention consists of maximizing function capacity after an illness has taken its toll. Strengthening healthy muscles after polio has reduced the functioning of others is an example of tertiary prevention.

Primary Prevention

Primary prevention of adolescent suicide entails strengthening social supports, enhancing parent-child communication, educating all members of a community as to the extent and causes of adolescent suicide, and working with adults to continue their parenting role together after differences may have caused dissolution of the companion/lover role in marriage. All children identify with both mothers and fathers. When parents war in the presence of a child, the component parts within the child are in conflict and he or she feels badly. Self-esteem is diminished. Desire to reduce the stress may result in suicide.

Special children, bright, gifted, sensitive, or attractive, feel the loneliness of the long-distance runner. Everyone needs social supports. Sometimes unique children and children with a severe disability such as a mutilated limb or with socially deviant feelings, such as homosexual attraction, may feel badly. Immigrant children may not be assimilated into the predominant subculture and feel isolated. Efforts should be made to enhance social bonding and reduce isolation. Some chil-

dren feel badly, but do not articulate the feeling. Programs in schools to facilitate parent-child and peer communications by training in emotional literacy lead to ventilation of pent-up emotion before it reaches self-destructive proportions and help individuals to draw others nearer to help.

Secondary Prevention

The first and most important step in secondary prevention (ie, identification of suicidal potential before the attempt) is to listen — and to listen with one's whole being, not just with one's ears. Is a child who is acting differently making you feel concerned? This is the task of primary care providers, parents, siblings, clergy, friends, and teachers. Rarely do psychiatrists see adolescents who have not yet been defined as having a problem. Those who kill themselves have usually communicated their desire to do so to someone before the act and have been ignored. We must learn to recognize those at risk and the signs of increasing intent to act.

Studies of successful suicides across all ages indicate that two-thirds to three-fourths of those who ultimately kill themselves visit a physician at least once in the last four months of their lives.[1, 51] Physicians must ask about depression and suicide, just as they ask about allergies. Both prevent needless deaths.

Evaluation[3, 5] of suicide potential involves taking a psychiatric history and evaluating the mental state with emphasis on intensity of depression, command hallucinations, and suicidal thoughts, intents, plans, and attempts. Giving away personal property, lack of future plans, and recent loss denote increased risk. Discussion as to whether to hospitalize a patient is based on clinical judgment about past history (eg, past attempts enhance risk), patients' current living situation, availability of social supports, degree of depression, and effect of evaluation and initiation of treatment. A moderately suicidal person is easier to manage outside the hospital in the presence of supportive family members and friends than a mildly suicidal one who is a loner. All suicidal threats and gestures must be taken seriously. *Never* in the acute situation should a suicidal person be challenged, argued with, or given facile interpretations, no matter how accurate. Risk factors for both completion and for attempts must be evaluated, as attempts may be a cry for help, but a failure in the calculation of response, and the person dies. Whether the patient is hospitalized or treated at home, access to objects or drugs which may be used in attempts must be guarded.[1, 2]

The thrust of crisis work in secondary prevention is establishment of social supports, opening lines of communication, and initiating therapeutic interventions. Patients and their families should feel that something definitive has been done. After an evaluation, a sufficient number of options should be elucidated so that any problems that may attend home care are minimized. Every effort should be made to treat patients with as little interference with their daily routine as possible. Re-evaluation of patients' self-destructive potential during the acute phase should be done as frequently as clinical judgment dictates. Frequency of visits, if the individual is treated as an outpatient, depends to a great degree on how much a primary care physician can depend on others in the community in terms of family, friends, and clergy to provide social support and opportunity for ventilation and option exploring and to call the physician should the condition worsen.

Communication of the desire to die is very characteristic of suicide completers.[11] Children do give warnings by mentioning suicide, gesturing, threatening, or attempting.[7] The Samaritans of Rhode Island and comparable groups elsewhere play a critical role in a community by educating teachers, clergy, families, fellow students, primary caregivers, and suicidal individuals to recognize signs of increasing suicidal preoccupation and by providing an immediate resource for help. Education is probably the most effective way to prevent adolescent suicide. All community caregivers, but especially teachers, clergy, and those of the medical profession, must be instructed in causes of suicide, diagnosis, treatment, and prophylaxis, Caregivers and other key community supports must be aware of groups at special risk — the depressed, schizophrenic, substance abusers, and past attempters. The great majority of suicides in psychiatric patients are preventable if treated early and aggressively.[5] A child is the most sensitive barometer of the climate of the marriage of the parents. Therefore, all evaluation should include assessment of family, especially with respect to interaction among family members and violent and suicidal behavior of parents.

Tertiary Prevention

Tertiary prevention involves the prevention of debilitating effects after an attempt or completion has occurred. While this also is a community task, the role of the psychiatrist is clear here.

Attempters often attempt again, and most of those who die by suicide have attempted. This is a group of high risk. In addition, we know that the immediate post-hospital phase is a time of special risk. Social supports must be rallied, lines of communication and accessibility opened, and follow-up of sufficient frequency and intensity arranged.

After a suicide has occurred, others around the victim are at greater risk. Contagion occurs. This is a phenomenon whereby a number of suicides occur among those who knew a suicide. Examples of this have been reported in Massachusetts, New York, and Texas. In addition, if a suicide follows loss of someone by death, the relatives of the suicide are at increased risk because of shared loss and shared genetic endowment.

Suicide changes family dynamics. Attribution of blame and guilt leads to conflict, unnecessary further aggravation of pain, and in some instances separation or divorce. "Safeplace," a survivors' group sponsored by the Samaritans, provides the opportunity for sharing of the sequelae of a suicide and a means of coping with the loss.

A study by Deykin et al[52] of an intervention program designed to reduce suicidal self-destructive behavior among high-risk adolescents aged 13 to 17 years old, combined a program of community education and direct service to youths who required emergency care for self-inflicted injuries. The intervention program was effective in increasing the subjects' compliance with medical regimens. To a lesser degree, the intervention facilitated early help-seeking among adolescents with suicidal thoughts and appeared to diminish overall occurrence of emergency room admissions for suicidal behavior.

Familiarity with principles of assessment and systemic application of them to case management facilitates treatment engagement, improves social functioning, and reduces risk of repeat suicide attempts and suicide.[19] In view of the frequency with which adolescents present at general hospitals with attempted suicide, a strong case can be made for development of organized crisis services to coordinate assessment, management, and follow-up.[53, 54]

Finally, research is needed to understand better the interaction of genetic predisposition, specific psychiatric illness, social support, impulsivity, precipitating factors, role modeling, and cultural sanctions. Why do some children survive the extreme stress of family disruption and personal abuse, while other talented sensitive children who appear to have everything going for them elect to die by suicide? Life is not being dealt a good hand. It is playing a poor hand well. We must help ourselves and others to define ways of coping together with the inevitable sorrows and joys of the human experience.

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Adolescent Suicide Fatalities

Incidence of Adolescent Suicide in Rhode Island Has Doubled in the Past Ten Years

William Q. Sturner, MD

A review of teenage suicide (self-inflicted deaths occurring before the 20th birthday) gives some credence to the statement that such fatalities have "increased to epidemic proportions," wherein 5,000 American adolescents commit suicide each year. According to the National Center for Health Statistics, the adolescent suicide rate has tripled, while rates for the rest of the population have remained stable.

In Rhode Island, a similar increase has taken place, coinciding with and perhaps resulting from a change in the State Medical Examiner system beginning in 1975. Prior to this time, statistical records indicated but a slight increase of the few cases recorded in the two decades since 1955 (Table 1).[1] A new rigorous investigation and classification system of all traumatic deaths was then instituted which has the effect of almost quadrupling the number of teenage suicides in that year.

During the decade 1975-1985, the average number of teenage suicides was more than double the average number which occurred from 1965-1974 (Table 2).[2] All fatalities have been examined and investigated in the same manner since that time, covering the past eleven and a half years, wherein 96 cases of adolescent suicide have been recorded. All background data, scene investigations, postmortem procedures, toxicologic results, and family interviews when conducted are taken into consideration in a similar fashion when arriving at the classification of suicide. The high-water mark of 1977, during which 18 cases were recorded, is somewhat offset by lesser-case years, as there were only four in 1976 and three in 1978. The average number of cases remains at approximately eight per year.

A study of adolescent suicides and its relationship to perinatal factors has been previously reported, and much of the historical data elicited from a review of these 70 cases will be used in the subsequent discussion.[3]

The location of birth of each suicide victim is noted in Table 3. Twenty per cent of these cases were born outside of Rhode Island, including five in military hospitals. Data from other teenage fatalities (homicides and accidents), as well as natural deaths, are not available for comparison. Age, race, sex, and marital status are noted in Table 4. The four married victims were not living with their spouses at the time of suicide.

Causes of death and methods employed are listed in Table 5. About 30 per cent of the deaths are due to firearms, whereas 28 per cent are due to hanging. Fatalities from firearms have been reported to be higher in adolescent suicides occurring in other jurisdictions. Males, the predominate sex in this series of adolescent suicides, also tend to use guns and hanging in their self-destructive acts. Females are more prone to use less violent ways, such as drugs and carbon monoxide.[4]

Table 6 denotes the number of victims who have alcohol, drugs, or both, including THC, a marihuana metabolite, in their system at the time of death, as well as those who exhibited a past history of drug abuse. There was, as shown, some overlap in each category exhibited by four patients.

A striking finding, as shown in Table 7, is the number of patients giving self-destructive "warnings," such as offering verbal threats, engaging in previous attempts, or leaving notes. When taken together, approximately 80 per cent of all victims provide warning signs; and once again, some individuals overlap in all three areas.

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Among the other factors which were assessed, of special interest were those individuals who were ill or "physically impaired." A representative sample of these incidents is shown in Table 8. Some are of the psychiatric variety ("migraine"), whereas the majority are organic ailments (epilepsy). The rate of psychiatric disorders, such as depression and schizophrenia in youngsters is probably less than 50 per cent, but a family history of suicidal behavior and psychiatric conditions is often elicited.[5]

Table 1. Adolescent Suicides in Rhode Island (10-19 year olds): 1955-1974

Year	Number
1955	0
1956	3*
1957	3*
1958	2
1959	0
1960	2
1961	4
1962	2
1963	0
1964	8
1965	3
1966	6
1967	3
1968	2
1969	3
1970	2
1971	6
1972	5
1973	4
1974	3
Total	61

* Age group: 15-19 years old
** Vital Statistics records; medical examiners data non-existent

Additional background information which is more difficult to assess includes unemployment, which has been shown to be a factor in suicides of young adults in their 20s. "Job satisfaction," was not examined, however, since it was too difficult to obtain, or even assess when reasonably reliable data were provided.

This teenage group also demonstrates various "school problems," which are outlined in Table 9. It should be pointed out that, since four of the victims were "A" students, such difficulties were not necessarily or solely academic. One student, for example, had lost an election for class president before he took his own life. Some were known to have disciplinary problems, whereas others were scheduled to be seen by the principal for "aggressive behavior." It should be noted that the "baseline" for most of these conditions in this age group are unknown, and thus it is difficult to ascertain whether the incidence of various problems reported here differ from behavior shown by the general adolescent population.

An analysis of the family background is interesting and possibly a key predisposing factor in suicide behavior. A representative group of such instances is noted in Table 10. Previous suicides by siblings, parents, friends, and schoolmates are noted in many of the histories of these youngsters and are obviously of importance. This is strong and compelling evidence to substantiate that family members should be provided with therapeutic intervention by trained counselors immediately following a suicide in a relative or loved one. The same reasoning prevails in a class, grade, an entire school, or combinations of these, following a self-destructive act by one of the students.

Table 2. Adolescent Suicides in Rhode Island: 1975-1986

Year	Number
1975	11
1976	4
1977	18
1978	3
1979	8
1980	6
1981	11
1982	7
1983	5
1984	7
1985	10
1986	6*
Total	96**

* as of July 1, 1986
** determined under the new medical examiner system

Table 3. Place of Birth

Rhode Island	58
Connecticut	2
Massachusetts	2
Ohio	1
California	1
Minnesota	1
Germany (Military)	1
France (Military)	1
Canal Zone (Military)	1
Unknown (US Navy & Army Hospital Birth)	2
Total	70*

* data from January 1975-March 1983

Table 4. Basic Data

Total	70
Age	12-19 years
Race	All Caucasian
Sex	59 male, 11 female
Marital status	4 married but not living with spouse

Anecdotal episodes which were instructive in assessing the historical circumstances, various stresses, and other predisposing factors in teenage suicide will be briefly outlined:

Case Studies

Case 1: An 18-year-old male was partying with friends, went to the bathroom and opened the medicine cabinet, returned to bed, but asked his girlfriend to "lie next to him and not to leave him." He had told her earlier that he "wanted to be with his father," who had committed suicide a few years earlier. He was also scheduled to appear in court for assault and battery charges the following day. Empty pill vials were found in his girlfriend's apartment. Toxic levels of barbiturate were present in his system.

Case 2: A 17-year-old male, a top student in his class, had an altercation with another schoolmate and was subsequently told to appear at the principal's office for a "hearing." The boy, living with his divorced mother, expressed concern about "discipline," which he said "he couldn't handle." He called two female friends shortly before he died of a self-inflicted gunshot wound.

Case 3: A 13-year-old boy died of asphyxia due to hanging by an electrical cord. He had been in an argument with his 15-year-old brother earlier in the day. He was scheduled to appear in Family Court the following week. There were no prior suicide attempts. Furniture was broken in the bedroom, apparently from a tussle. He was found by a 9-year-old sibling who called the father who began cardiopulmonary resuscitation until the rescue unit arrived. The boy was dead on arrival at a nearby hospital.

Table 5. Causes of Death

	Total	Male	Female
Gunshot wounds	28	24	4
Hanging	20	18	2
Drug Overdose	9	6	3
Carbon Monoxide	5	4	1
Drowning	4	4	0
Jumped from height	3	2	1
Self-immolation	1	1	0

Case 4: A 16-year-old male was found hanging in the residence of his father's girlfriend. His parents were undergoing divorce proceedings. He had also recently broken up with his girlfriend; she had become pregnant but had "lost" the baby. His request to live with his mother was refused. The father and his girlfriend were moving out of state and the son did not wish to accompany them. Alcohol and barbiturates were present in his system.

Case 5: A 16-year-old male shot himself in the head at his residence. Two days previously, the police had inquired about a robbery that had taken place at a local convenience store. He had denied knowledge of the incident, but circumstances soon indicated that he had committed the crime. A "loud bang" was heard in his upstairs bedroom upon the return of the police for further questioning.

Case 6: A 14-year-old female was found in the woods with a gunshot wound of the chest. She was reported as a "runaway juvenile" by her stepfather the previous evening. She had apparently done this before, but, "other than problems at home," had no record of criminal activity. No child abuse reports had been filed with the local authorities. No notes were found.

Case 7: A 17-year-old male had been "discovered" smoking marihuana. He telephoned some friends as well as his father, who lived out of state, expressing concerns and fears, and then suspended himself with a ligature. It was suggested that he could not face any "punishment" to be administered for this act.

Case 8: An 18-year-old male had been depressed because of his being a school drop-out as well as his lack of employment. He was described as "energetic but rebellious." Depression was also noted in other members of the immediate family. He used drugs and "overdosed" two years previously. He was found hanging in his basement.

Case 9: A combination of poor grades and other "pleasures" caused a 17- and a 15-year-old (from different towns and schools) to inhale exhaust fumes together in a family car on a desolate country road. Neither victim had apparently attempted suicide in the past or was known to be depressed. Personal effects found at the scene established their school difficulties. This was the only instance in which a "suicide pact" was successful with two teenagers.

Table 6. Toxicology

	Total	Male	Female
Positive alcohol	25	23	2
Positive drugs	6	5	1
Positive THC (screening test)	8	7	1
History of previous drug abuse	15	14	1

* four victims were positive for a combination of alcohol, THC, and other drugs

Table 7. Adolescent Suicide: Warning Signs

	Total	Male	Female
Previous attempts (one female had two attempts)	15	14	1
Notes left (4 had 2 or more notes; 2 males and 2 females)	26	18	8
Verbal threats (one female announced five times)	20	17	3
Victim left tape cassette	1	0	1

Total 8. Adolescent Suicide: Physical Problems

— On crutches from injury
— Ulcer symptoms with treatment
— Epilepsy with retardation (2)
— Acting strange with memory loss
— Injured in two different car accidents
— Treated for "cold and flu" at home
— Repeated headaches

Summary

Teenage suicides have increased, at least in part, because of the thorough and consistent documentation of these fatalities by newly emerging or improving medical examiner systems. The incidence of adolescent suicide in Rhode Island has doubled during the past ten years compared to the previous two decades. An overwhelming preponderance of males was observed. All victims were Caucasian. Firearms accounted for approximately 33 per cent of the deaths, with hanging being the next most common method, employed in about 28 per cent. Family problems, physical incapacity, and school difficulties were prominent background features in many of the victims. The prevalence of several varieties of "warning signs" was demonstrated in a high percentage of these victims. The likelihood that this intensifies guilt in the survivors calls for attention and appropriate intervention plans for the families and peers of these tragic victims.

Table 9. Adolescent Suicide: School Problems

"A" Students	4
"Drop-out"	1
Lost election as school president	1
Wanted to quit school and go to California	1
Physical altercation with upcoming disciplinary hearing	1
"Over-achiever"	1
Recent local suicide at same school; two weeks of depression	1

Table 10. Adolescent Suicide: Family Problems

— Father hanged self in jail one month previously
— Cousin committed suicide one week previously
— Two brothers hanged selves in past
— Mother refused to let son live with her
— Living in dorm; angry with father who had girlfriend
— Father a coach; expected son to superachieve in athletics
— 13-year-old sibling died a natural death
— Father committed suicide; child wanted to be with him
— Mother kicked victim and brother out of house (changed schools)
— "Problems" with father
— "Poor relationship with father"
— "Wanted to live with mother; she refused"

Acknowledgements

Professor Lewis P. Lipsett contributed invaluable insights in reviewing the manuscript. Bernice Reilly, RN, provided informative data from a review of the case files. The assistance of Edward Martin, State Registrar of Vital Statistics, Rhode Island Department of Health, is greatly appreciated.

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The "Development" of Adolescent Suicide

Further Neonatal and Longitudinal Epidemiological Studies Are Needed to Detect the Suicide-Prone Adolescent

Lewis P. Lipsitt, PhD

When an adolescent death occurs in circumstances corroborating suicide, the death certificate is usually signed out with words such as "suffocation by hanging, self-inflicted," or "fatal brain injury, self-induced, hand-gun." The causal chain of events, including psychological circumstances, immediate instigators, and the environment of the individual at the time of death, is seldom honored with a detailed exploration of the conditions leading to the young person's deliberate destruction of himself or herself.

It is not my purpose to criticize the process by which the fact of suicide is discovered and then laid quickly to rest with the body of the victim. Often the quietude inherent in the process is genuinely motivated to alleviate the guilt and distress of the surviving family members and peers. Considerations relating to whether the family can admit the cause of death are also decisive factors in the decision to close the case quickly and avoid undue interference with grieving survivors.

Further, there is some legitimate concern that excessive notice of the circumstances of the death will somehow generate morbid interest in suicide and thus move others who may be so disposed to more readily act on their inclinations. Imitative suicide is an aspect of the problem that must be addressed if we are to come to a well-informed understanding of adolescent suicide generally.

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Yet there have been virtually no studies of the developmental precursors of this sudden lowering of the threshold for self-destruction in some adolescents when a famous individual commits suicide.

Social customs, admittedly conceived with a benevolent intent, tend to obscure the real precursors of the final life events of persons committing suicide. Even more serious, we lack the kind of developmental information about persons whose lives eventuate in suicide that would be truly needed to understand the phenomenon, better to predict probable victims, and to implement appropriate preventative interventions. Part of the problem in failing to understand the origins of suicide is our inherently non-historical approach, accounting both for our avoidance of incisive inquiry into causes of death after suicide, and our continuing lack of scientific knowledge about the *development* of suicidal individuals.

Too frequently we are satisfied with the gratuitous answer "Depression," upon inquiring, "Why did he do it?" The fact is that often the term was never applied to the victim before this fatal incident. His or her "depression" was never noted by family members (except now, perhaps, in retrospect) or on medical examination. Moreover, most persons with depression do *not* commit suicide. Depression as a "cause" of suicide thus can hardly be satisfying, because depression as a factor in the case goes without saying on the one hand, yet says virtually nothing as to the chain of causes leading to this particular individual's demise. If depression is a major "cause" of death by suicide, why were there no black suicides whatever in a Rhode Island study of 52 consecutive adolescent suicides in the state?

Social custom and well-meaning attempts at medical compassion have had some regrettable effects upon the very important data-gathering process relating to our understanding of adolescent suicide. The status of our knowledge about the origins of suicide has suffered also from the lack of longitudinal studies of children and adolescents that could illuminate the processes by which individuals endure crises in their lives, acquire successful coping patterns, and, in effect, save their own lives with adequate psychological defenses against threats to their self-esteem. Individuals' own biographical and life-event contributions to their suicide are usually grossly bypassed, not only in individual postmortems, but in studies of human development. In short, we do not know enough about the development of psychological self-regulatory mechanisms in the maturing infant, child, and adolescent truly to understand the determinants of suicide, either in the generality or in most specific cases.

Western society is now confronted with a proliferation of adolescent suicide attempts and a rate of adolescent suicide representing, conservatively, three times the incidence of just three decades ago. It is especially important that we intensify our research, using longitudinal methods in which the persons studied are followed over a long term with the best procedures that technological advances can now provide. Surely in an age when adolescents utilize the props of a high-tech society to instrument their own demise (with drugs, cars, and sophisticated weapons) we can appropriate tools of study that are their equal. Our lack of definitive knowledge in this regard is voiced repeatedly not just by family members who are caught by surprise, or by stunned schoolmates, but by the best-trained suicide experts in the world. Lack of real ability to detect the persons most likely to kill themselves is fairly universal.

The life-span developmental perspective

As a behavior and development specialist sensory and learning processes of infants and children, beginning in the earliest moments of life and extending into adolescence and young adulthood, I am fascinated by the diversity of human destinies that seem to have originated in seemingly similar early life circumstances. Conversely, a wide variety of early life histories from birth onward, some seemingly far from pernicious, can eventuate in similar outcomes, eg adolescent suicide. The problem of the developmental psychologist is to try to understand especially the paradoxes or "developmental surprises," especially the outcomes that do not seem to be well predicted by the circumstances. We need to know much more, for example, about the apparently "immunizing conditions" of life that seem to blunt the potentially dire effects of other conditions, particularly those that present great hazards to development, such as the early death of a parent, or childhood rape. By the same token, we need to know more about the historical conditions of later life that can threaten terribly the life and livelihood of a person who apparently has had no previous psychological debility, but in whom one condition of distress leads to total inability to accept the life condition, and eventually to suicide. This has been reported with increasing frequency in young adults arrested and jailed for the first time.

The longitudinal study of human subjects exemplified

In my own work, the babies are scarcely out of the delivery room when they arrive in my laboratory at Women and Infants Hospital of Rhode Island. There I and my associates use a polygraph and computer to study bodily and behavioral functioning of the neonate. We link the derived profiles with (1) the antecedents of the infant's development during the fetal period, and other life conditions relevant to the child's fate, such as familial characteristics, environmental factors, and birth risk conditions, and with (2) the developmental consequences of these characteristics manifested early in their lives. To these ends we observe and measure the infant's respiration, heart rate, bodily movements, and sucking behavior both as the infant lies before us without any particular intrusions, and also in response to various kinds of stimulation, such as tones, visual stimuli, tastes, and smells.

Although this sort of enterprise is imprecise at best, we and other developmental researchers of the past few decades have been able to document some rather interesting "conditions of infancy" that had not been well documented earlier. We have been greatly aided in this search by recent advances in laboratory technology as well as improvements in methodological sophistication of the behavioral sciences. Of particular relevance for the points I wish to make here, we now know that newborns come into the world with all of their sensory systems functioning, not yet like those of adults, but they are sensing creatures nonetheless. They are even capable of learning

rudimentary responses especially relating to their survival in the earliest days of life.

Newborns can come to recognize their own mother's odor by the sixth day of life. They are capable of reciprocally interacting with their caretakers, and will even seem to imitate facial gestures of an attending person. While some behavior processes require much closer investigation, we are sure even now that newborns are remarkably acute tasters of fluids going into their mouths contingent on their own behavior. When the newborn's sucking behavior produces liquid on the tongue, a remarkable process goes on, such that the child will either further accept the fluid or reject it depending upon its hedonic quality. Newborns savor some experiences, and they reject others. They are sensitive to the pleasures and annoyances of sensation.

Newborns self-regulate their sucking behavior and their heart rates as components of the psychobiological act of ingestion. When the fluid for which they suck is sweeter, they slow down their sucking rates within bursts of sucking (the savoring process), but they take fewer and shorter rest periods and thus end up sucking more times per minute for the sweeter fluid. Moreover, their heart rates go higher for the sweeter fluids (even within bursts of sucking and with length of the sucking burst controlled statistically), despite the fact that they are sucking more slowly and presumably using less energy in so doing.

There are, of course, individual differences in the psychobiological processes just as there are in weight, length, and eye color of babies. Some infants are more hedonic than others. The mothers tell us this, too — for example, that their first child was a ravenous feeder while this one seems not to care that much. Then, too, the baby's behavior is direclty affected by the apparent developmental and intact status of its nervous system. Babies who have been subjected to stress, have been born prematurely or small for dates, or required resuscitation at delivery, typically have flatter hedonic slopes than babies born under conditions of risk.

My students and colleagues and I have been studying these kinds of behavior processes and psychophysiological reactions of the very young infant to relate these early characteristics to subsequent behavior. In particular we want to find out about the subtle ways in which constitutional factors already evident at birth may interact with environmental or experiential conditions jointly to determine life outcomes of the older child, and indeed the adult. Thus, for example, we have explored the relationship between the newborn's sucking avidity to the child's eventual attachment to its mother at one year of age. We follow these youngsters to test them later with age-appropriate developmental tasks. One such procedure at one year of age is to note the extent to which the child objects, with crying and fussing, when its mother leaves the room and only a stranger remains. We found out that the children who are more securely attached to their mothers, who can tolerate her absence and greet her warmly upon her return, are the ones who on average were more avid at birth. We suppose, although this is hypothetical, that the child who feeds well early in life is more rewarding to its mother, that mother and baby have smoother interactions with one another in many respects, and that thus the child and mother one year later are simply "getting along better" together.

Another aspect of our research program in the Child Study Center at Brown University, where we participated as one of 12 institutions in the National Collaborative Perinatal Project beginning in 1959, involved studying the origins of cerebral palsy, mental retardation, and other neurological and psychological disorders. The children of that study were followed to seven years of age with pediatric, psychological, and speech-hearing examinations, and a vast amount of data on them is available — 50,000 children nationwide. They are at this writing 21 to 26 years of age.

Although we are in the early stages of follow-up on this population, it is already apparent that the risk conditions of young people tend to cumulate over time, so that for most people, "one damned thing leads to another." Eventually the early-risk child will become at even greater risk for debility and early death. This goes for behavioral functioning as much as it does for frankly physical jeopardy. This scenario of compounding risk factors in the lives of individuals who are in early jeopardy may be especially likely in the behavioral areas. All of us who are familiar with the adaptive coping behaviors of the physically disabled child have marveled at the compensatory mechanisms and adjustments that are often, indeed usually, made. Self-regulatory behavior starts very early, and much that happens to human subjects along their life courses has to do with failures of self-regulatory mechanisms, either inbuilt or acquired. Self-defensive behaviors that protect us from debility or demise are very largely learned patterns of response, based upon coping

experiences with stressful conditions in our lives. Some children who are vulnerable on the basis of early risk factors, either constitutional or in their environments, will in fact acquire learned protective patterns that will confound the predictions of later developmental deficit. They turn out well when we thought they were surely headed for trouble. Although the child developmentalist likes to have his predictions borne out, there is something very rewarding about knowing that there are attenuating factors that can help keep the vulnerable child from succumbing. Considerable effort is now being made to understand the special capacities of these children for overcoming handicaps. Eventually our field will be able to be more precise in this regard. Already there are data to suggest that, although the children of schizophrenics are vulnerable themselves for schizophrenia, there are immunizing conditions of life that can obviate that outcome.

Even life destinies involving physical demise in which, for example, the coroner signs off a death as from brain damage involving a motorcycle accident, involve important psychological factors as precursors. There is a whole host of *behavioral misadventures* that should figure very prominently in the work of the forensic pathologist as "causes" of the death.

As the Surgeon General of the United States Public Health Service indicated in a very important book titled *Healthy People*, most human subjects who diew before the age of 25 succumb from accidents, homicide, and suicide. That is a well known fact among pathologists. It must also be quite obvious that such deaths are essentially "psychologically caused," whether by failing to observe or obey a stop sign, swimming out farther than one can safely swim back, failing to wear headgear on a motorcycle, imbibing large quantities of alcohol before driving, failing to control one's anger toward another person, or inability to cope with a shame-inducing experience.

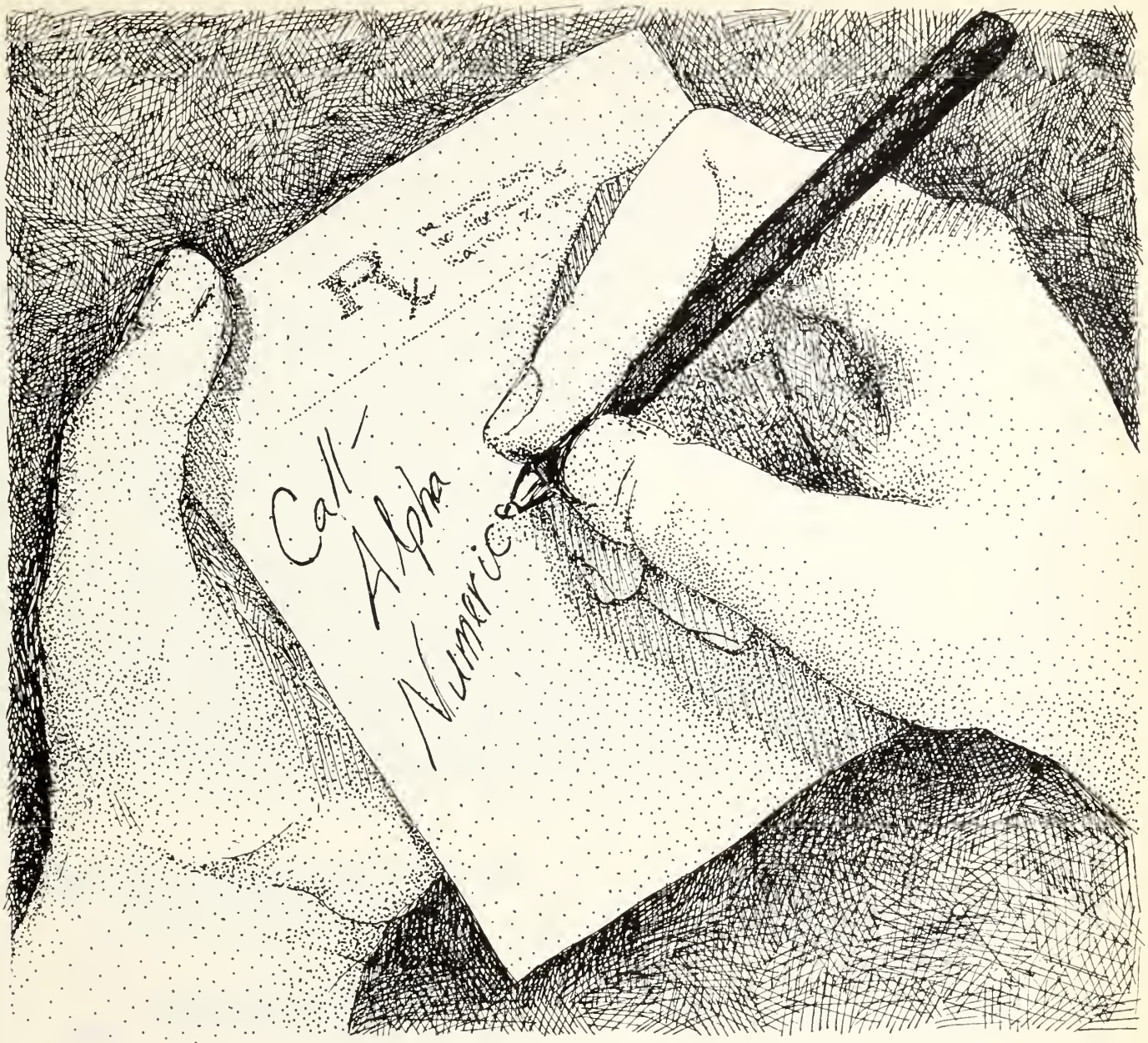
A final comment

While some of the precursors of adolescent suicide and other "behavioral misadventures" are fairly obvious, only intensive epidemiological studies of various life outcomes will ultimately reveal the important interactions that take place among multiple determinative variables jointly to cause adolescent suicide. There are already numerous hints in the research literature to suggest that important constitutional differneces exist in the disposition toward suicide, and that these interact with environmental and psychological factors to "overdetermine" the outcome. Race differences in adolescent suicide, for example, have already been mentioned. Also, significantly more adolescent males than females commit suicide. Moreover, there are striking differences between males and females in the styles of self-destruction selected, with males engaging in more vigorous, aggressive modes than females. Taking these facts into consideration, and considering seasonal, climatic, and light-dark correlates of rates of suicide, it is not unlikely that testosterone levels or other hormonal agents will be found on closer investigation to be related to suicide in adolescents. Until the extensive longitudinal study of life-development patterns and outcomes is mounted, we are likely to remain quite ignorant of the kind of information we will need to stop the still rising rate of adolescent suicide.



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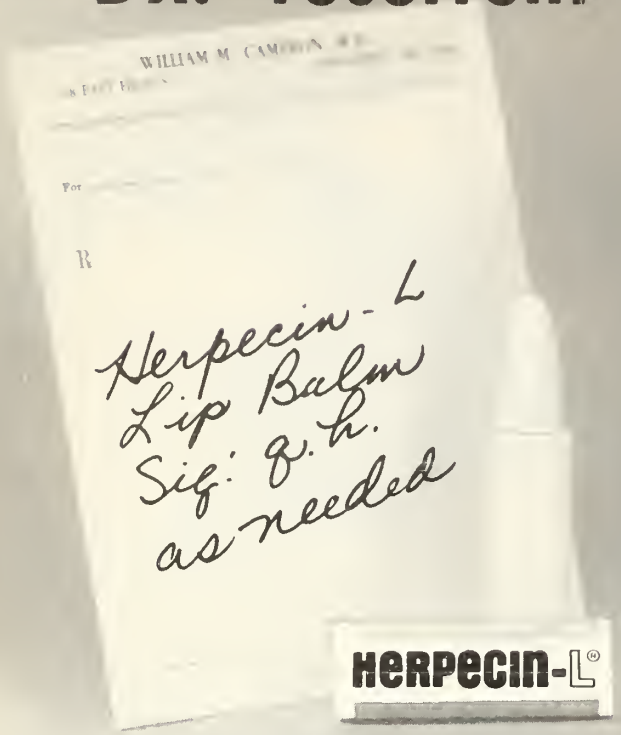
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	cimetidine 400 mg h.s.	23%	34%	43%	66
UK, Ireland, Australia[2]	ranitidine 150 mg h.s.	8%‡	14%‡	23%‡	243
	cimetidine 400 mg h.s.	21%	34%	37%	241

*p=0.02
†p=0.01
‡p≤0.004
%=life-table estimates
All patients were permitted prn antacids for relief of pain.

These two trials used the currently recommended dosing regimen of cimetidine (400 mg h.s.) and ranitidine (150 mg h.s.). A comparison of other dosing regimens has not been studied.

The studied dosing regimens are not equivalent with respect to the degree and duration of acid suppression or suppression of nocturnal acid.

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See next page for references and
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One tablet at bedtime for maintenance therapy in healed duodenal ulcer patients

References:
1 Silvis SE, Griffin J, Hardin R, et al: Final report on the United States multicenter trial comparing ranitidine to cimetidine as maintenance therapy following healing of duodenal ulcer. *J Clin Gastroenterol* 1985,7(6) 482-487.
2 Gough KR, Korman MG, Bardhan KD, et al: Ranitidine and cimetidine in prevention of duodenal ulcer relapse: A double-blind, randomised, multicentre, comparative trial. *Lancet* 1984,ii-659 662.
3 Data available on request, Glaxo Inc.

ZANTAC® 150 Tablets
(ranitidine hydrochloride)
ZANTAC® 300 Tablets
(ranitidine hydrochloride)

BRIEF SUMMARY OF PRODUCT INFORMATION

See complete product information before prescribing. The following is a brief summary.

INDICATIONS AND USAGE: ZANTAC® is indicated in:
1 Short-term treatment of **active duodenal ulcer**. Most patients heal within four weeks.
2 **Maintenance therapy** for duodenal ulcer patients at reduced dosage after healing of acute ulcers.
3 The treatment of **pathological hypersecretory conditions** (eg, Zollinger-Ellison syndrome and systemic mastocytosis).
4 Short-term treatment of **active, benign gastric ulcer**. Most patients heal within six weeks and the usefulness of further treatment has not been demonstrated.
5 Treatment of **gastroesophageal reflux disease (GERD)**. Symptomatic relief commonly occurs within one or two weeks after starting therapy. Therapy for longer than six weeks has not been studied.

In active duodenal ulcer, active, benign gastric ulcer, hypersecretory states; and GERD, concomitant antacids should be given as needed for relief of pain.

CONTRAINDICATIONS: ZANTAC® is contraindicated for patients known to have hypersensitivity to the drug.

PRECAUTIONS: General: 1 Symptomatic response to ZANTAC® therapy does not preclude the presence of gastric malignancy. 2 Since ZANTAC is excreted primarily by the kidney, dosage should be adjusted in patients with impaired renal function. Caution should be observed in patients with hepatic dysfunction since ZANTAC is metabolized in the liver.

Laboratory Tests: False positive tests for urine protein with Multistix® may occur during ZANTAC therapy, and therefore testing with sulfosalicylic acid is recommended.

Drug Interactions: Although ZANTAC has been reported to bind weakly to cytochrome P-450 in vitro, recommended doses of the drug do not inhibit the action of the cytochrome P-450-linked oxygenase enzymes in the liver. However, there have been isolated reports of drug interactions which suggest that ZANTAC may affect the bioavailability of certain drugs by some mechanism as yet unidentified (eg, a pH-dependent effect on absorption or a change in volume of distribution).

Carcinogenesis, Mutagenesis, Impairment of Fertility: There was no indication of tumorigenic or carcinogenic effects in lifespan studies in mice and rats at doses up to 2,000 mg/kg/day.

Ranitidine was not mutagenic in standard bacterial tests (*Salmonella, E coli*) for mutagenicity at concentrations up to the maximum recommended for these assays.

In a dominant lethal assay, a single oral dose of 1,000 mg/kg to male rats was without effect on the outcome of two matings per week for the next nine weeks.

Pregnancy: ***Teratogenic Effects; Pregnancy Category B:*** Reproduction studies have been performed in rats and rabbits at doses up to 160 times the human dose and have revealed no evidence of impaired fertility or harm to the fetus due to ZANTAC. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers: ZANTAC is secreted in human milk. Caution should be exercised when ZANTAC is administered to a nursing mother.

Pediatric Use: Safety and effectiveness in children have not been established.

Use in Elderly Patients: Ulcer healing rates in elderly patients (65 to 82 years of age) were no different from those in younger age groups. The incidence rates for adverse events and laboratory abnormalities were also not different from those seen in other age groups.

ADVERSE REACTIONS: The following have been reported as events in clinical trials or in the routine management of patients treated with oral ZANTAC®. The relationship to ZANTAC therapy has been unclear in many cases. Headache, sometimes severe, seems to be related to ZANTAC administration.

Central Nervous System: Rarely, malaise, dizziness, somnolence, insomnia, and vertigo. Rare cases of reversible mental confusion, agitation, depression, and hallucinations have been reported, predominantly in severely ill elderly patients.

Cardiovascular: Rare reports of tachycardia, bradycardia, and premature ventricular beats.

Gastrointestinal. Constipation, diarrhea, nausea vomiting, and abdominal discomfort/pain.

Hepatic: In normal volunteers, SGPT values were increased to at least twice the pretreatment levels in 6 of 12 subjects receiving 100 mg qid IV for seven days, and in 4 of 24 subjects receiving 50 mg qid IV for five days. With oral administration there have been occasional reports of reversible hepatitis, hepatocellular or hepatocanalicular or mixed, with or without jaundice.

Musculoskeletal: Rare reports of arthralgias.

Hematologic: Rare reports of reversible leukopenia, granulocytopenia, thrombocytopenia, and pancytopenia.

Endocrine: Controlled studies in animals and man have shown no stimulation of any pituitary hormone by ZANTAC and no antiandrogenic activity, and cimetidine-induced gynecomastia and impotence in hypersecretory patients have resolved when ZANTAC has been substituted. However, occasional cases of gynecomastia, impotence, and loss of libido have been reported in male patients receiving ZANTAC, but the incidence did not differ from that in the general population.

Integumental: Rash, including rare cases suggestive of mild erythema multiforme, and, rarely, alopecia.

Other: Rare cases of hypersensitivity reactions (eg, bronchospasm, fever, rash, eosinophilia) and small increases in serum creatinine.

DOSAGE AND ADMINISTRATION: Active Duodenal Ulcer: The current recommended adult oral dosage is 150 mg twice daily. An alternate dosage of 300 mg once daily at bedtime can be used for patients in whom dosing convenience is important. The advantages of one treatment regimen compared to the other in a particular patient population have yet to be demonstrated.

Maintenance Therapy: The current recommended adult oral dosage is 150 mg at bedtime.

Pathological Hypersecretory Conditions (such as Zollinger-Ellison Syndrome): The current recommended adult oral dosage is 150 mg twice a day. In some patients it may be necessary to administer ZANTAC® 150-mg doses more frequently. Doses should be adjusted to individual patient needs, and should continue as long as clinically indicated. Doses up to 6 g/day have been employed in patients with severe disease.

Benign Gastric Ulcer: The current recommended adult oral dosage is 150 mg twice a day.

GERD: The current recommended adult oral dosage is 150 mg twice a day.

See full prescribing information for dosage adjustment for patients with impaired renal function.

HOW SUPPLIED: ZANTAC® 300 Tablets (ranitidine hydrochloride equivalent to 300 mg of ranitidine) are yellow, capsule-shaped tablets embossed with "ZANTAC 300" on one side and "Glaxo" on the other. They are available in bottles of 30 (NDC 0173-0393-40) and unit dose packs of 100 tablets (NDC 0173-0393-47).

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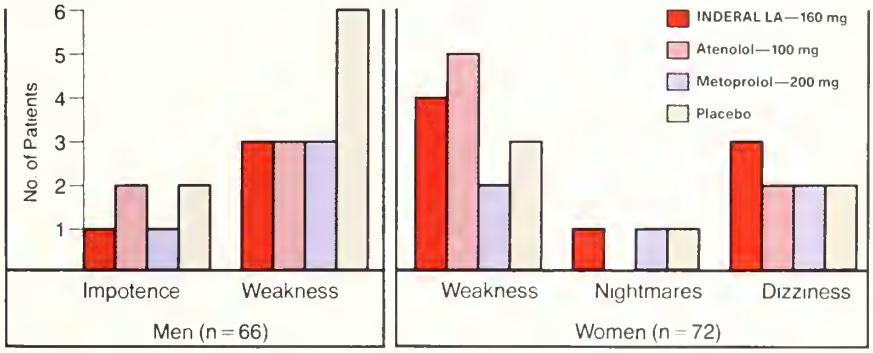
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Propranolol hydrochloride (INDERAL® LA): Propranolol is contraindicated in 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with propranolol.

Hydrochlorothiazide: Hydrochlorothiazide is contraindicated in patients with anuria or hypersensitivity to this or other sulfonamide-derived drugs.

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Propranolol hydrochloride (INDERAL® LA): CARDIAC FAILURE. Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated, and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or propranolol should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction following *abrupt* discontinuance of propranolol therapy. Therefore, when discontinuance of propranolol is planned the dosage should be gradually reduced and the patient carefully monitored. In addition, when propranolol is prescribed for angina pectoris, the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If propranolol therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute propranolol therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

THYROTOXICOSIS. Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

MAJOR SURGERY. The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

Nonallergic Bronchospasm (eg, chronic bronchitis, emphysema)— PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD, IN GENERAL, NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution, since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

DIABETES AND HYPOGLYCEMIA. Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin. Hypoglycemic attacks may be accompanied by a precipitous elevation of blood pressure.

Hydrochlorothiazide: Thiazides should be used with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. In patients with impaired renal function, cumulative effects of the drug may develop.

Thiazides should also be used with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma.

Thiazides may add to or potentiate the action of other antihypertensive drugs. Potentiation occurs with ganglionic or peripheral adrenergic-blocking drugs.

Sensitivity reactions may occur in patients with a history of allergy or bronchial asthma.

The possibility of exacerbation or activation of systemic lupus erythematosus has been reported.

PRECAUTIONS

Propranolol hydrochloride (INDERAL® LA): GENERAL. Propranolol should be used with caution in patients with impaired hepatic or renal function. Propranolol is not indicated for the treatment of hypertensive emergencies.

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that propranolol may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

CLINICAL LABORATORY TESTS. Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS. Patients receiving catecholamine-depleting drugs, such as reserpine, should be closely observed if propranolol is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity, which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY. Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies, in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

PREGNANCY. Pregnancy Category C. Propranolol has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximal recommended human dose. There are no adequate and well-controlled studies in pregnant women. Propranolol should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

NURSING MOTHERS. Propranolol is excreted in human milk. Caution should be exercised when propranolol is administered to a nursing mother.

PEDIATRIC USE. Safety and effectiveness in children have not been established.

Hydrochlorothiazide: GENERAL. Periodic determination of serum electrolytes to detect possible electrolyte imbalance should be performed at appropriate intervals.

All patients receiving thiazide therapy should be observed for clinical signs of fluid or electrolyte imbalance: namely, hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when the patient is vomiting excessively or receiving parenteral fluids. Medication such as digitalis may also influence serum electrolytes. Warning signs irrespective of cause are: Dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea and vomiting.

Hypokalemia may develop, especially with brisk diuresis, when severe cirrhosis is present, or during concomitant use of corticosteroids or ACTH.

Interference with adequate oral electrolyte intake will also contribute to hypokalemia. Hypokalemia can sensitize or exaggerate the response of the heart to the toxic effect of digitalis (eg, increased ventricular irritability). Hypokalemia may be avoided or treated by use of potassium supplements, such as foods with a high potassium content.

Any chloride deficit is generally mild and usually does not require specific treatment, except under extraordinary circumstances (as in liver or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction, rather than administration of salt, except in rare instances when the hyponatremia is life-threatening. In actual salt depletion, appropriate replacement is the therapy of choice.

Hyperuricemia may occur or frank gout may be precipitated in certain patients receiving thiazide therapy.

Insulin requirements in diabetic patients may be increased, decreased, or unchanged. Diabetes mellitus which has been latent may become manifest during thiazide administration.

If progressive renal impairment becomes evident, consider withholding or discontinuing diuretic therapy.

Thiazides may decrease serum PBI levels without signs of thyroid disturbance.

Calcium excretion is decreased by thiazides. Pathologic changes in the parathyroid gland with hypercalcemia and hypophosphatemia have been observed in a few patients on prolonged thiazide therapy. The common complications of hyperparathyroidism, such as renal lithiasis, bone resorption, and peptic ulceration, have not been seen. Thiazides should be discontinued before carrying out tests for parathyroid function.

DRUG INTERACTIONS. Thiazide drugs may increase the responsiveness to tubocurarine.

The antihypertensive effects of thiazides may be enhanced in the postsympathectomy patient. Thiazides may decrease arterial responsiveness to norepinephrine. This diminution is not sufficient to preclude effectiveness of the pressor agent for therapeutic use.

PREGNANCY. Pregnancy Category C. Thiazides cross the placental barrier and appear in cord blood. The use of thiazides in pregnancy requires that the anticipated benefit be weighed against possible hazards to the fetus. These hazards include fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult.

NURSING MOTHERS. Thiazides appear in human milk. If use of the drug is deemed essential, the patient should stop nursing.

PEDIATRIC USE. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Propranolol hydrochloride (INDERAL® LA): Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular. Bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System. Lightheadedness; mental depression manifested by insomnia; lassitude; weakness; fatigue; reversible mental depression progressing to catatonia; visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place; short-term memory loss; emotional lability; slightly clouded sensorium; and decreased performance on neuropsychometrics.

Gastrointestinal. Nausea; vomiting; epigastric distress; abdominal cramping; diarrhea; constipation; mesenteric arterial thrombosis; ischemic colitis.

Allergic. Pharyngitis and agranulocytosis; erythematous rash; fever combined with aching and sore throat; laryngospasm and respiratory distress.

Respiratory. Bronchospasm.

Hematologic. Agranulocytosis; nonthrombocytopenic purpura; thrombocytopenic purpura.

Auto-Immune. In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous. Alopecia; LE-like reactions; psoriasiform rashes; dry eyes; male impotence; and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes, and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

Hydrochlorothiazide:

Gastrointestinal. Anorexia; gastric irritation; nausea; vomiting; cramping; diarrhea; constipation; jaundice (intrahepatic cholestatic jaundice); pancreatitis; sialadenitis.

Central Nervous System. Dizziness; vertigo; paresthesias; headache; xanthopsia.

Hematologic. Leukopenia; agranulocytosis; thrombocytopenia; aplastic anemia.

Cardiovascular. Orthostatic hypotension (may be aggravated by alcohol, barbiturates, or narcotics).

Hypersensitivity. Purpura; photosensitivity; rash; urticaria; necrotizing angiitis (vasculitis, cutaneous vasculitis); fever; respiratory distress, including pneumonitis; anaphylactic reactions.

Other. Hyperglycemia; glycosuria; hyperuricemia; muscle spasm; weakness; restlessness; transient blurred vision.

Whenever adverse reactions are moderate or severe, thiazide dosage should be reduced or therapy withdrawn.

* The appearance of these capsules is a registered trademark of Ayerst Laboratories.

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1. Ravid M, Lang R, Jutrin I. The relative antihypertensive potency of propranolol, oxprenolol, atenolol, and metoprolol given once daily. *Arch Intern Med* 1985;145:1321–1323.

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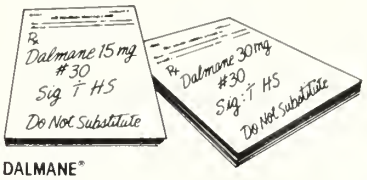
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References: 1. Kales J, *et al. Clin Pharmacol Ther 12* 691-697, Jul-Aug 1971. 2. Kales A, *et al. Clin Pharmacol Ther 18*.356-363, Sep 1975 3. Kales A, *et al. Clin Pharmacol Ther 19*.576-583, May 1976 4. Kales A, *et al. Clin Pharmacol Ther 32*.781-788, Dec 1982 5. Frost JD Jr, DeLucchi MR. *J Am Geriatr Soc 27*.541-546, Dec 1979 6. Dement WC, *et al. Behav Med*, pp 25-31, Oct 1978 7. Kales A, Kales JD. *J Clin Psychopharmacol 3* 140-150, Apr 1983. 8. Tennant FS, *et al.* Symposium on the Treatment of Sleep Disorders, Teleconference, Oct 16, 1984 9. Greenblatt DJ, Allen MD, Shader RI. *Clin Pharmacol Ther 21*.355-361, Mar 1977.



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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening, in patients with recurring insomnia or poor sleeping habits, in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

Contraindications: Known hypersensitivity to flurazepam HCl, pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patients to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Withdrawal symptoms rarely reported; abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase, and paradoxical reactions, *e.g.* excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect. *Adults*: 30 mg usual dosage, 15 mg may suffice in some patients. *Elderly or debilitated patients*: 15 mg recommended initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

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Please see adjacent page for references and summary of product information.

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Rhode Island Medical Journal

November 1986
Volume 69, Number 11

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Seebert J. Goldowsky, MD, at left, Editor-in-Chief of the Rhode Island Medical Journal *for over quarter century — See page 507*

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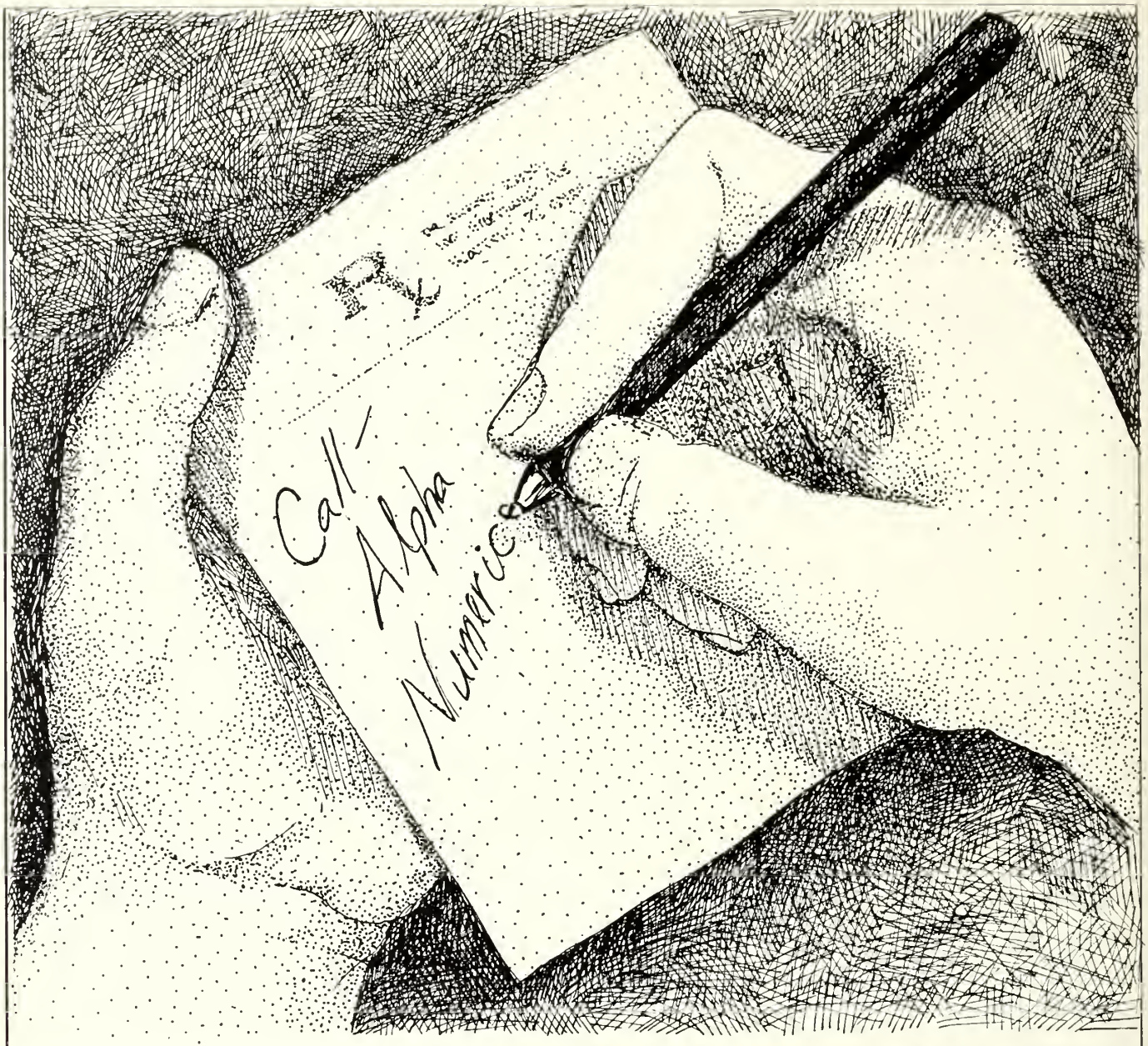
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a better time for her...
and
PREMARIN®
(Conjugated Estrogens Tablets)

Now the evidence looks better than ever

Significantly reduced risk of endometrial hyperplasia

Endometrial hyperplasia was significantly reduced when progestin was added to PREMARIN therapy for more than ten days a month.[1-4] The risk of endometrial hyperplasia may also be reduced through cyclic administration of unopposed, low-dose PREMARIN.

Effect on lipids—an important feature

PREMARIN used alone does not adversely affect lipid levels. In fact, a clinical study has shown a significant increase in HDL cholesterol—from 49.7 mg/dL to 56.4 mg/dL—and decrease in LDL cholesterol—from 165.1 mg/dL to 138.1 mg/dL—after one year of therapy with PREMARIN, 0.625 mg.[5]

Low-dose control of menopausal symptoms*

PREMARIN effectively relieves vasomotor symptoms, such as hot flashes. When estrogen deficiency is limited to atrophic vaginitis, PREMARIN® (conjugated estrogens) Vaginal Cream restores the vaginal environment to its premenopausal state.

The most widely used, most extensively studied estrogen worldwide.

PREMARIN®
(Conjugated Estrogens Tablets)

Most trusted for more reasons

*PREMARIN is indicated for moderate-to-severe vasomotor symptoms.

Please see following page for brief summary of prescribing information.

For moderate-to-severe vasomotor symptoms

PREMARIN®
(Conjugated Estrogens Tablets)



0.3 mg 0.625 mg 0.9 mg 1.25 mg 2.5 mg

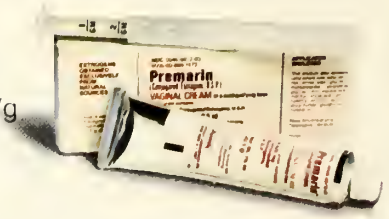
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For atrophic vaginitis

PREMARIN®
(Conjugated Estrogens)

Vaginal Cream

0.625mg/g



BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION AND PATIENT INFORMATION, SEE PACKAGE CIRCULARS.)*

PREMARIN® Brand of conjugated estrogens tablets, USP
PREMARIN® Brand of conjugated estrogens Vaginal Cream in a nonliquefying base

1 ESTROGENS HAVE BEEN REPORTED TO INCREASE THE RISK OF ENDOMETRIAL CARCINOMA

Three independent case control studies have reported an increased risk of endometrial cancer in postmenopausal women exposed to exogenous estrogens for more than one year. This risk was independent of the other known risk factors for endometrial cancer. These studies are further supported by the finding that incidence rates of endometrial cancer have increased sharply since 1969 in eight different areas of the United States with population-based cancer reporting systems, an increase which may be related to the rapidly expanding use of estrogens during the last decade. The three case control studies reported that the risk of endometrial cancer in estrogen users was about 4.5 to 13.9 times greater than in nonusers. The risk appears to depend on both duration of treatment and on estrogen dose. In view of these findings, when estrogens are used for the treatment of menopausal symptoms, the lowest dose that will control symptoms should be utilized and medication should be discontinued as soon as possible. When prolonged treatment is medically indicated, the patient should be reassessed on at least a semiannual basis to determine the need for continued therapy. Although the evidence must be considered preliminary, one study suggests that cyclic administration of low doses of estrogen may carry less risk than continuous administration; it therefore appears prudent to utilize such a regimen. Close clinical surveillance of all women taking estrogens is important. In all cases of undiagnosed persistent or recurring abnormal vaginal bleeding, adequate diagnostic measures should be undertaken to rule out malignancy. There is no evidence at present that "natural" estrogens are more or less hazardous than "synthetic" estrogens at equiestrogenic doses.

2 ESTROGENS SHOULD NOT BE USED DURING PREGNANCY

The use of female sex hormones, both estrogens and progestogens, during early pregnancy may seriously damage the offspring. It has been shown that females exposed in utero to diethylstilbestrol, a non-steroidal estrogen, have an increased risk of developing in later life a form of vaginal or cervical cancer that is ordinarily extremely rare. This risk has been estimated as not greater than 4 per 1,000 exposures. Furthermore, a high percentage of such exposed women (from 30% to 90%) have been found to have vaginal adenosis, epithelial changes of the vagina and cervix. Although these changes are histologically benign, it is not known whether they are precursors of malignancy. Although similar data are not available with the use of other estrogens, it cannot be presumed they would not induce similar changes. Several reports suggest an association between intrauterine exposure to female sex hormones and congenital anomalies, including congenital heart defects and limb reduction defects. One case control study estimated a 4.7-fold increased risk of limb reduction defects in infants exposed in utero to sex hormones (oral contraceptives, hormone withdrawal tests for pregnancy, or attempted treatment for threatened abortion). Some of these exposures were very short and involved only a few days of treatment. The data suggest that the risk of limb reduction defects in exposed fetuses is somewhat less than 1 per 1,000. In the past, female sex hormones have been used during pregnancy in an attempt to treat threatened or habitual abortion. There is considerable evidence that estrogens are ineffective for these indications, and there is no evidence from well controlled studies that progestogens are effective for these uses. If PREMARIN is used during pregnancy, or if the patient becomes pregnant while taking this drug, she should be apprised of the potential risks to the fetus, and the advisability of pregnancy continuation.

DESCRIPTION: PREMARIN (conjugated estrogens, USP) contains a mixture of estrogens, obtained exclusively from natural sources, blended to represent the average composition of material derived from pregnant mares' urine. It contains estrone, equilin, and 17α-dihydroequilin, together with smaller amounts of 17α-estradiol, equilenin, and 17α-dihydroequilenin as salts of their sulfate esters. Tablets are available in 0.3 mg, 0.625 mg, 0.9 mg, 1.25 mg, and 2.5 mg strengths of conjugated estrogens. Cream is available as 0.625 mg conjugated estrogens per gram.

INDICATIONS AND USAGE: PREMARIN (conjugated estrogens tablets, USP): Moderate-to-severe *vasomotor* symptoms associated with the menopause. (There is no evidence that estrogens are effective for nervous symptoms or depression without associated vasomotor symptoms and they should not be used to treat such conditions.) **Osteoporosis (abnormally low bone mass).** Atrophic vaginitis. Kraurosis vulvae. Female castration.

PREMARIN (conjugated estrogens) Vaginal Cream is indicated in the treatment of atrophic vaginitis and kraurosis vulvae. PREMARIN HAS NOT BEEN SHOWN TO BE EFFECTIVE FOR ANY PURPOSE DURING PREGNANCY AND ITS USE MAY CAUSE SEVERE HARM TO THE FETUS (SEE BOXED WARNING).

Concomitant Progestin Use: The lowest effective dose appropriate for the specific indication should be utilized. Studies of the addition of a progestin for 7 or more days of a cycle of estrogen administration have reported a lowered incidence of endometrial hyperplasia. Morphological and biochemical studies of the endometrium suggest that 10 to 13 days of progestin are needed to provide maximal maturation of the endometrium and to eliminate any hyperplastic changes. Whether this will provide protection from endometrial carcinoma has not been clearly established. There are possible additional risks which may be associated with the inclusion of progestin in estrogen replacement regimens. (See PRECAUTIONS.) The choice of progestin and dosage may be important, product labeling should be reviewed to minimize possible adverse effects.

CONTRAINDICATIONS: Estrogens should not be used in women (or men) with any of the following conditions: 1. Known or suspected cancer of the breast except in appropriately selected patients being treated for metastatic disease. 2. Known or suspected estrogen-dependent neoplasia. 3. Known or suspected pregnancy (See Boxed Warning). 4. Undiagnosed abnormal genital bleeding. 5. Active thrombophlebitis or thromboembolic disorders. 6. A past history of thrombophlebitis, thrombosis, or thromboembolic disorders associated with previous estrogen use (except when used in treatment of breast or prostatic malignancy).

WARNINGS: Long-term continuous administration of natural and synthetic estrogens in certain animal species increases the frequency of carcinomas of the breast, cervix, vagina, and liver. There are now reports that estrogens increase the risk of carcinoma of the endometrium in humans. (See Boxed Warning.) At the present time there is no satisfactory evidence that estrogens given to postmenopausal women increase the risk of cancer of the breast, although a recent study has raised this possibility. There is a need for caution in prescribing estrogens for women with a strong family history of breast cancer or who have breast nodules, fibrocystic disease, or abnormal mammograms. A recent study has reported a 2- to 3-fold increase in the risk of surgically confirmed gallbladder disease in women receiving postmenopausal estrogens.

Adverse effects of oral contraceptives may be expected at the larger doses of estrogen used to treat prostatic or breast cancer or postpartum breast engorgement; it has been shown that there is an increased risk of thrombosis in men receiving estrogens for prostatic cancer and women for postpartum breast engorgement. Users of oral contraceptives have an increased risk of diseases, such as thrombophlebitis, pulmonary embolism, stroke, and myocardial infarction. Cases of retinal thrombosis, mesenteric thrombosis, and optic neuritis have been reported in oral contraceptive users. An increased risk of postsurgery thromboembolic complications has also been reported in users of oral contraceptives. If feasible, estrogen should be discontinued at least 4 weeks before surgery of the type associated with an increased risk of thromboembolism, or during periods of prolonged immobilization. Estrogens should not be used in persons with active thrombophlebitis, thromboembolic disorders, or in persons with a history of such disorders in association with estrogen use. They should be used with caution in patients with cerebral vascular or coronary artery disease. Large doses (5 mg conjugated estrogens per day), comparable to those used to treat cancer of the prostate and breast, have been shown to increase the risk of nonfatal myocardial infarction, pulmonary embolism and thrombophlebitis. When doses of this size are used, any of the thromboembolic and thrombotic adverse effects should be considered a clear risk.

Benign hepatic adenomas should be considered in estrogen users having abdominal pain and tenderness, abdominal mass, or hypovolemic shock. Hepatocellular carcinoma has been reported in women taking estrogen-containing oral contraceptives. Increased blood pressure may occur with use of estrogens in the menopause and blood pressure should be monitored with estrogen use. A worsening of glucose tolerance has been observed in patients on estrogen-containing oral contraceptives. For this reason, diabetic patients should be carefully observed. Estrogens may lead to severe hypercalcemia in patients with breast cancer and bone metastases.

PRECAUTIONS: Physical examination and a complete medical and family history should be taken prior to the initiation of any estrogen therapy with special reference to blood pressure, breasts, abdomen, and pelvic organs, and should include a Papanicolaou smear. As a general rule, estrogen should not be prescribed for longer than one year without another physical examination being performed. Conditions influenced by fluid retention such as asthma, epilepsy, migraine, and cardiac or renal dysfunction, require careful observation. Certain patients may develop manifestations of excessive estrogenic stimulation, such as abnormal or excessive uterine bleeding, mastodynia, etc. Prolonged administration of unopposed estrogen therapy has been reported to increase the risk of endometrial hyperplasia in some patients. Oral contraceptives appear to be associated with an increased incidence of mental depression. Patients with a history of depression should be carefully observed. Preexisting uterine leiomyomata may increase in size during estrogen use. The pathologist should be advised of estrogen therapy when relevant specimens are submitted. If jaundice develops in any patient receiving estrogen, the medication should be discontinued while the cause is investigated. Estrogens should be used with care in patients with impaired liver function, renal insufficiency, metabolic bone diseases associated with hypercalcemia, or in young patients in whom bone growth is not complete. If concomitant progestin therapy is used, potential risks may include adverse effects on carbohydrate and lipid metabolism.

The following changes may be expected with larger doses of estrogen:

a. Increased sulfobromophthalein retention.

b. Increased prothrombin and factors VII, VIII, IX, and X; decreased antithrombin 3; increased norepinephrine-induced platelet aggregability.

c. Increased thyroid binding globulin (TBG) leading to increased circulating total thyroid hormone, as measured by PBI, T4 by column, or T4 by radioimmunoassay. Free T3 resin uptake is decreased, reflecting the elevated TBG; free T4 concentration is unaltered.

d. Impaired glucose tolerance.

e. Decreased pregnanediol excretion.

f. Reduced response to metyrapone test.

g. Reduced serum folate concentration.

h. Increased serum triglyceride and phospholipid concentration. As a general principle, the administration of any drug to nursing mothers should be done only when clearly necessary since many drugs are excreted in human milk.

ADVERSE REACTIONS: The following have been reported with estrogenic therapy, including oral contraceptives: breakthrough bleeding, spotting, change in menstrual flow; dysmenorrhea; premenstrual-like syndrome; amenorrhea during and after treatment; increase in size of uterine fibromyomata; vaginal candidiasis; change in cervical erosion and in degree of cervical secretion; cystitis-like syndrome; tenderness, enlargement, secretion (of breasts); nausea, vomiting, abdominal cramps, bloating; cholestatic jaundice; chloasma or melasma which may persist when drug is discontinued; erythema multiforme; erythema nodosum; hemorrhagic eruption; loss of scalp hair; hirsutism; steepening of corneal curvature; intolerance to contact lenses; headache, migraine, dizziness, mental depression; chorea; increase or decrease in weight; reduced carbohydrate tolerance; aggravation of porphyria; edema; changes in libido.

ACUTE OVERDOSAGE: May cause nausea, and withdrawal bleeding may occur in females.

DOSAGE AND ADMINISTRATION:

PREMARIN® Brand of conjugated estrogens tablets, USP

1. *Given cyclically for short-term use only*: For treatment of moderate to severe *vasomotor* symptoms, atrophic vaginitis, or kraurosis vulvae associated with the menopause (0.3 to 1.25 mg or more daily). The lowest dose that will control symptoms should be chosen and medication should be discontinued as promptly as possible. Administration should be cyclic (eg, three weeks on and one week off). Attempts to discontinue or taper medication should be made at three- to six-month intervals.

2. *Given cyclically*: Female castration: Osteoporosis. Female castration—1.25 mg daily, cyclically. Adjust upward or downward according to response of the patient. For maintenance, adjust dosage to lowest level that will provide effective control. Osteoporosis—0.625 mg daily. Administration should be cyclic (eg, three weeks on and one week off).

Patients with an intact uterus should be monitored for signs of endometrial cancer and appropriate measures taken to rule out malignancy in the event of persistent or recurring abnormal vaginal bleeding.

PREMARIN® Brand of conjugated estrogens Vaginal Cream

Given cyclically for short-term use only: For treatment of atrophic vaginitis or kraurosis vulvae.

The lowest dose that will control symptoms should be chosen and medication should be discontinued as promptly as possible.

Administration should be cyclic (eg, three weeks on and one week off).

Attempts to discontinue or taper medication should be made at three-to-six month intervals.

Usual dosage range: 2 to 4 g daily, intravaginally, depending on the severity of the condition.

Treated patients with an intact uterus should be monitored closely for signs of endometrial cancer and appropriate diagnostic measures should be taken to rule out malignancy in the event of persistent or recurring abnormal vaginal bleeding.

References:

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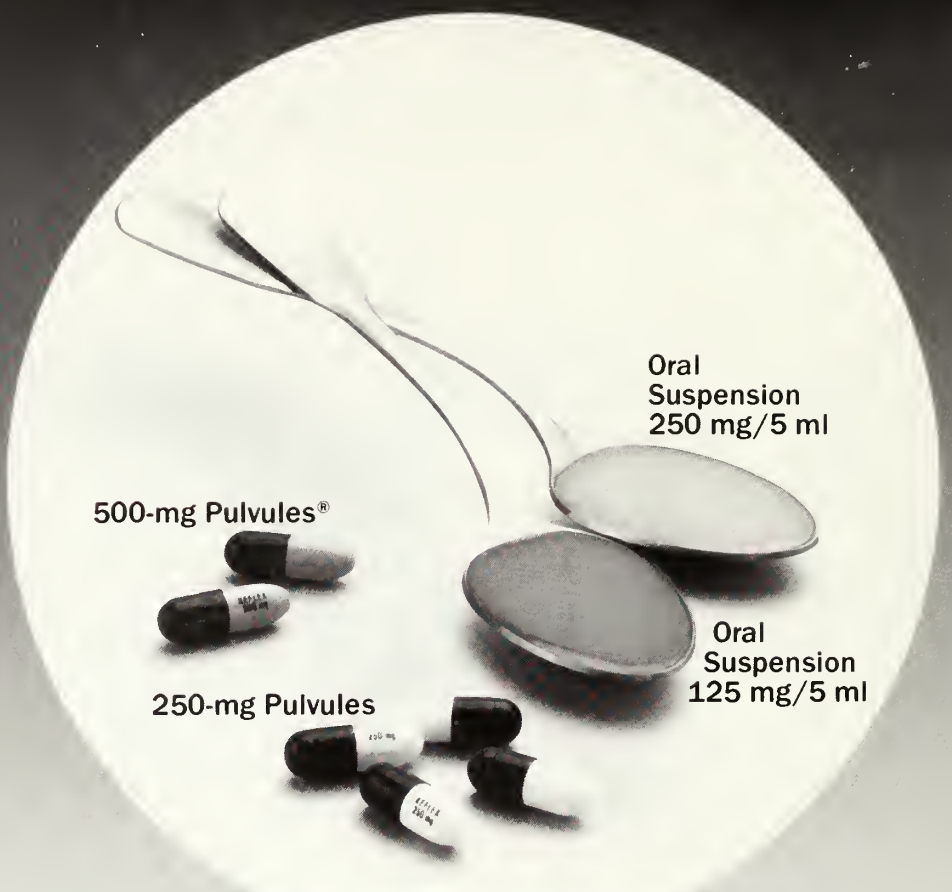
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Newsletter

RHODE ISLAND MEDICAL SOCIETY
November 1986

Peter D.T. Clarisse, MD, President
Jack A. Perkins, Editor

RIMS TESTIFIES BEFORE LIABILITY PANEL

The Blue Ribbon Commission established by Governor Edward DiPrete to examine the liability crisis in Rhode Island held its first public hearing on November 6. The commission received testimony from representatives of most business, professional, and social service groups.

Herbert Rakatansky, MD, Immediate Past-President, testified on behalf of the Society. Dr. Rakatansky suggested three solutions to the present crisis. His first, called the "best" solution, included a system which allows patients to be paid promptly, plus a strong and effective disciplinary component. Dr. Rakatansky indicated that the Society could cooperate with the Rhode Island Board of Licensure and Discipline to determine and enforce proper disciplinary measures.

Under this system the patient could receive compensation for specified "bad outcomes" from a fund maintained by physicians, health insurers, and consumers. This program would allow patients to receive timely payments without the necessity of proving negligence.

A second solution termed "better" is a modification of the current tort system. This would allow doctors to provide reimbursement to patients for their economic losses. All health insurance policies would include a surcharge to cover pain and suffering awards. The current system which allows patients to collect economic losses would be continued. However, the new proposal would establish a state-wide insurance program to cover pain and suffering awards.

The third solution offered by Dr. Rakatansky would place caps on pain and suffering awards plus restrictions on attorneys' fees. This system characterized as "good" does not accomplish the goals of prompt payments for patients and effective discipline when necessary. Dr. Rakatansky noted that it is important to separate payment to the patient from discipline of the physician.

Kenneth Liffmann, MD, RIMS Treasurer and Chairman of the Joint Underwriting Association (JUA), testified on behalf of the JUA. Dr. Liffmann discussed the current and projected financial status of the JUA.

Governor DiPrete established this commission last summer and expects to receive its report and recommendations prior to the commencement of the 1987 session of the Rhode Island General Assembly. The Governor intends to review the recommendations and have legislation drafted and introduced in the legislature. The legislation is intended to be broad in nature and to address all classes of liability.

Peter D.T. Clarisse, MD, RIMS President, is a member of the panel appointed by the Governor. Mark Pfeiffer, director of the Department of Business Regulations, is chairman.

MORE ON TORT REFORM

RIMS is a member of the newly-formed Rhode Island Tort Reform Coalition (RITRC), which is seeking a legislative solution to the liability crisis. The coalition, led by the Rhode Island Federation of Chambers of Commerce, includes the Hospital Association of Rhode Island, Rhode Island Hospital, the Rhode Island Dental Association, the Providence Chamber of Commerce, the Blackstone Valley Chamber of Commerce, the Rhode Island Bar Association, and others.

RITRC (continued)

Edwin Madden, MD, an orthopedic surgeon in Kent County represents the Medical Society. RITRC will represent the common interests of business, the municipalities, and the professions in seeking to move tort reform through the Rhode Island General Assembly in 1987. The Coalition may support recommendations of the Governor's Special commission on liability or draft legislation of its own.

RITRC expects to work in consonance with the American Tort Reform Association (ATRA), a national organization dedicated to reform of the liability system. The next RITRC meeting will be held on November 20.

COMPETITION IN HEALTH INSURANCE HEATS UP

One alarming side effect of Rhode Island's increasingly competitive health insurance market is an understandably confused public. With many different insurance carriers aggressively marketing their wares, patients are faced with difficult decisions. RIMS decided to join in this advertising war, but not in an attempt to sell a product.

The Society placed an ad in The Providence Journal encouraging patients to discuss the various insurance plans with their physicians. RIMS produced a brochure comparing the various health plans and distributed it to its members for reference in responding to their patients' concerns. The Society has also offered assistance to individuals who do not have a physician to turn to in this matter.

On November 1 a new physician payment practice designated the "Prudent Buyer Policy" was instituted by BC/BS. Under this new policy Blue Shield's participating physicians will be paid no more for a given service than they receive from any other insurance carriers. Ocean State Physicians Health Plan, because of financial constraints, had paid only 80 per cent of the fees paid by BC/BS.

As a result of this policy change, the Blues are currently being sued by Ocean State. Ocean State claims that the new "Prudent Buyer Policy" is an anti-competitive practice designed to force them out of business. Thus far 250 physicians have resigned from Ocean State since the policy change was announced by the Blues in the summer of 1986.

The US Justice Department is also probing into the matter. US Attorney Lincoln C. Almond has characterized the Justice Department's involvement as a "formal investigation." The Justice Department's Antitrust Division can issue "demand letters", similar to subpoenas, to obtain documents for examination. Justice is attempting to determine what impact the BC/BS "Prudent Buyer Policy" will have on the Rhode Island market. The investigation could conceivably reach the federal courts if a civil complaint is filed.

The Providence Journal reported that Dr H. Denman Scott, director of the Rhode Island Department of Health, and Mark A. Pfeiffer, director of the Department of Business Regulation, have commented that the new Blues' policy "could retard the development of consumer choices of health benefits plans in Rhode Island". Scott and Pfeiffer indicated to the Journal that they will seek legislation to provide their Departments with regulatory powers governing the relationship between physicians and health insurance carriers.

SOCIETY DISCUSSES ISSUES WITH CANDIDATES

During October RIMS members met with incumbent Governor Edward DiPrete and Bruce Sundlun, candidates for Rhode Island Governor, and incumbent Lieutenant Governor Richard Licht and Susan Farmer, candidates for Lieutenant Governor. These meetings enabled the Society to query the candidates on the issues most important to the medical community.

The overriding concern expressed to the candidates regarded the malpractice crisis. Each candidate appeared well acquainted with the issue and sympathetic to RIMS concerns. Governor DiPrete has appointed a special commission to address the liability

crisis (see page 497). He expects to consider the commission's forthcoming recommendations and have legislation drafted for introduction in the 1987 General Assembly, which opens on January 6.

Lieutenant Governor Licht, the highest ranking Democratic statewide officeholder, could potentially be an important ally when the issue is considered in the legislature. He agreed with RIMS that the current system is not working, and that an alternative is needed.

AMENDMENT FOURTEEN DEFEATED

Rhode Island voters in a recent state election in November soundly defeated proposed consitutional Amendment Fourteen by a vote of 65 per cent to 35 per cent.

The Rhode Island Medical Society House of Delegates, among the many groups opposed to this amendment, had issued the folowing statement in September:

> RIMS opposes any attempts by the government to dictate to the physicians what may and may not be done in the best interest of the patient. We oppose this amendment.

The objection of the Society was based on potential governmental intervention into a wide range of medical practices. The amendment would have placed legal restrictions, by state authority, on the use of "living wills", durable power of attorney, and the discontinuation of life-support systems or other life-extending measures for people who have terminal, irreversible disease.

The Amendment was one of fourteen which appeared on the November ballot.

RIMS COUNCIL CONTINUES WORK ON PLANNING

RIMS President Peter D.T. Clarisse, MD, called a special conference meeting of the Council to continue the study of the Society's need for long-range planning. On October 17 and 18 the Council met with Bruce Balfe, Vice President for Issue Planning and Management of the American Medical Association, in a continuing effort to determine through an examination of its activities the appropriate direction of the Society.

The conference was a crucial step toward implementing the recommendations of the American Association of Medical Society Executives to establish long-range plans for the Society. Discussion at the conference centered on how RIMS can best position itself in the changing environment for medical practice.

The Council noted that the Society has made several adjustments to meet the changing needs of its membership; however a long-range plan is lacking. President Clarisse has challenged the Society during the coming months to set its priorities and goals (see President's Page, page 513).

INTERIM MEETING OF AMA

The interim meeting of the House of Delegates of the American Medical Association (AMA) will be held December 7-10 in Las Vegas, Nevada. RIMS will be represented by Peter D.T. Clarisse, MD, President; John J. Cunningham, MD, AMA Delegate; Charles P. Shoemaker, MD, Alternate AMA Delegate; and Norman A. Baxter, PhD, Executive Director.

At the November 3 Executive Committee meeting, the RIMS delegation received authorization to introduce a resolution in Las Vegas calling upon the AMA to develop a report concerning the availability of nurses. A nursing shortage has become a growing concern, and RIMS is seeking the support of the AMA in addressing the matter.

The delegation will also bring to the attention of the AMA House the policy change at Blue Cross and Blue Shield of Rhode Island (BC/BS), effective November 1, involving the new "Prudent Buyer Policy", which alters BC/BS physician payment practices.

The AMA House of Delgates meets twice a year to establish policies and positions of the Association.

CONGRESSIONAL WRAP-UP

The 99th Congress came to a close with the passage of much health legislation. In the waning days of the session, Congress addressed measures to battle drug abuse, improve immigration laws, boost drug exports, restrict vaccine-injury liability, and further reform Medicare and Medicaid.

Two far-reaching budget bills were signed into law this year containing several provisions relating to Medicare and Medicaid. Congress modified Reagan Administration policies which they considered to be unfair. Because of this action, the legislative branch may have turned the corner in regaining control of the Medicare program, which had been lost to the White House in 1981.

The new law will provide physicians with a fee increase of 3.2 per cent starting January 1, 1987. Physician's fees under the Medicare program have remained frozen for nearly three years. Hospitals will receive an increase in payments of 1.15 per cent retroactive to October 1, 1986.

Observations of the Medicare Prospective Payment System (PPS) over the past two years led Congress to enact safeguards to assure quality care for hospital-discharged Medicare patients. Hospitals are now required to maintain discharge-review mechanisms to ensure that Medicare patients continue to receive quality follow-up care upon discharge. Also, the Secretary of Health and Human Services is mandated to draft legislation reforming the Medicare payment-by-diagnosis program to consider illness severity and case complexity.

The method employed to calculate the yearly increase in the deductible paid by Medicare recipients for hospital stays has been altered. This year the deductible, based on the cost of one day in the hospital, rose from $400 to $492. In 1987 the figure would have increased to $572. However, Congress instituted a cap of $520 on the 1987 deductible. Future increases will be limited each year to the percentage change received by hospitals.

Finally, the new law allows states to offer Medicaid coverage to children up to age 5, the disabled, and pregnant women who have incomes below the poverty level but do not qualify for welfare.

CONGRESS EXTENDS HEALTH INSURANCE COVERAGE

Employers of twenty or more employees who maintain group-health-insurance plans are required under a newly enacted federal law to permit laid-off workers to continue their insurance at the group rate. Also, the provision applies to spouses, widows and other dependents who would lose coverage due to death or divorce. The legislation appears to be a preliminary step by Congress to assist the approximately 35 million Americans who do not have health insurance coverage. With the legislative branch firmly in control of the Democrats after the recent election, further efforts toward expanding coverage are likely.

VACCINE-INJURY COMPENSATION PROGRAM

Congress recently passed federal legislation that would establish a national vaccine-injury compensation program designed to bypass the courts. Claimants dissatisfied with judgements handed down under the new federal system could still have access to the courts but would then forfeit their right to return to the new federal system.

Awards under the new program would be restricted to $250,000 for pain and suffering or death benefits plus economic losses. This legislation will not become effective until Congress establishes a payment mechanism.

GAO STUDIES COSTS FOR ELDERLY

A report by Congress's General Accounting Office (GAO) stated that "the unanticipated, often catastrophic cost of long-term care is the major threat to the financial well-being of the elderly." Because of fewer adult children and more working wives, senior citizens may anticipate declining support from family members. This reduction in family-provided home care will lead to out-of-pocket health-care costs increases for the elderly, according to the GAO.

Rhode Island Medical Journal

November 1986
Volume 69, Number 11

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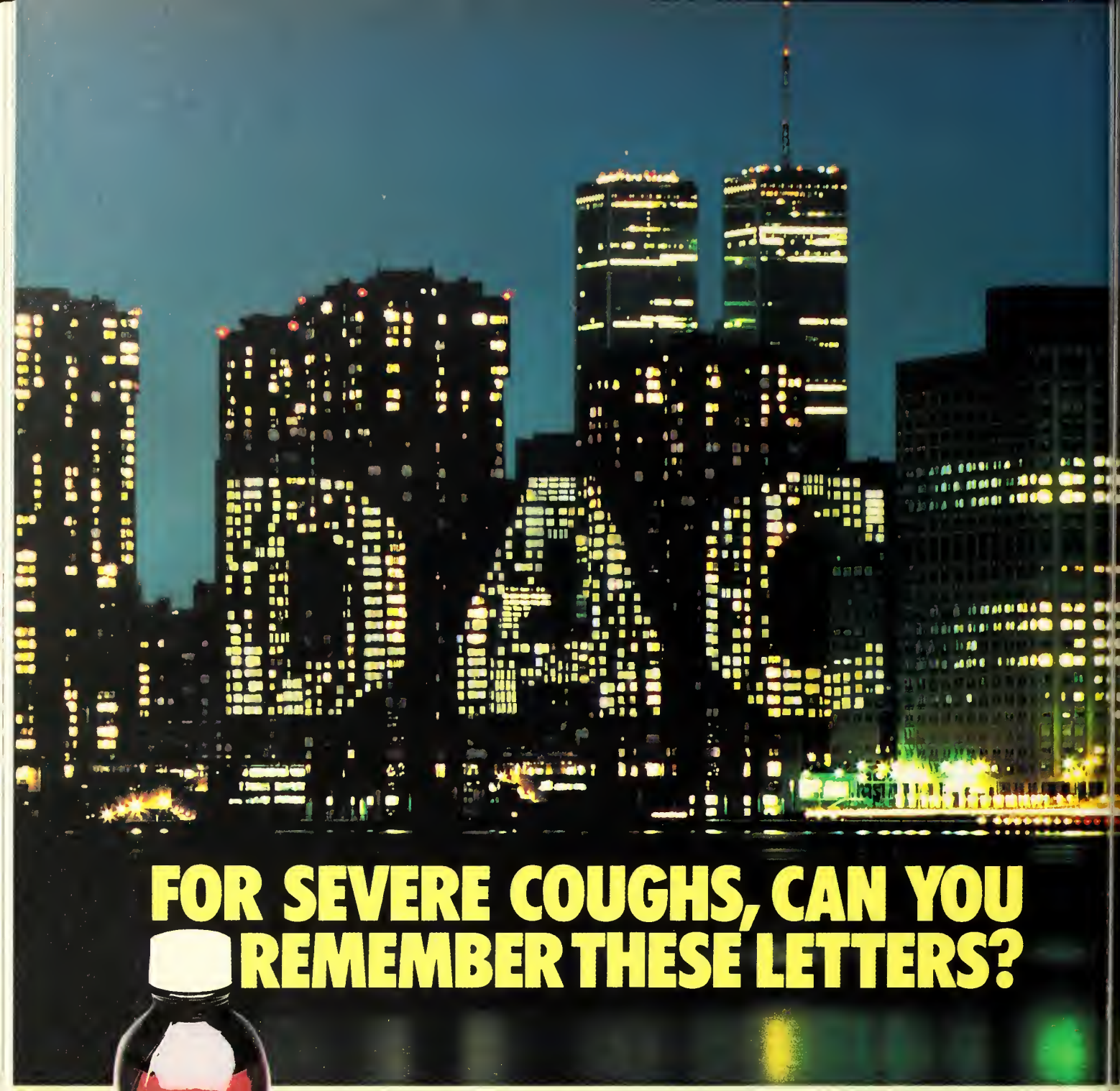
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EDITORIAL

A Tribute to Seebert J. Goldowsky

The professional career of Seebert J. Goldowsky, who now celebrates his twenty-sixth anniversary as Editor-in-Chief of the Rhode Island Medical Journal, covers more than 50 years of distinguished and faithful service to medicine, to its practitioners and to this community.

A 1924 alumnus of Classical High School in Providence, Goldowsky graduated summa cum laude from Brown University and received his M.D. degree, also summa cum laude, from Harvard Medical School in 1932. After completing his graduate education in surgery at Beth El Hospital in Boston, Boston City Hospital, Charles V. Chapin Hospital and Mt. Sinai Hospital in New York, he entered the practice of surgery in Providence's East Side in 1937. In the ensuing years, many professional affiliations and honors were accorded to him including his appointment as Surgeon-in-Chief at the Miriam Hospital and as Consultant in Surgery at the Rhode Island Hospital, Charles V. Chapin Hospital and Roger Williams General Hospital. Except for military service in the European Theater of Operations during World War II, Dr. Goldowsky devoted his entire medical career to the Providence region.

Upon the fortieth anniversary of his medical school graduation in 1972, Goldowsky retired from active surgical practice and became the Medical Director of Blue Cross and Blue Shield of Rhode Island. He held this post for the next decade and he currently serves as a consultant to the Rhode Island Department of Mental Health, Retardation and Hospitals.

This illustrious medical career sprang from a most unusual source. According to Dr. Goldowsky, his father, Bernard Manuel Goldowsky, was the first Jewish detective in Rhode Island and, ". . . those who knew him will concede that he was a colorful character." The elder Goldowsky arrived in New York City from Lithuania with his family at the age of nine and after following his younger brother to Texas for a brief and unsuccessful stint as a door-to-door salesman, he returned to New York City. In answer to a help wanted advertisement in a New York newspaper, he found himself applying for a job with the Pinkerton Detective Agency, was promptly hired and then sent to the Boston office of the Agency. While conducting an investigation in Providence, he met and earned the admiration of the late Patrick Parker, Chief of Detectives of the Providence Police Department. Providence was then, as now, the world's jewelry manufacturing center and the loss of even small amounts of precious metals to inside thievery created serious problems for the industry. After an introduction by Parker to the industry's leaders, the elder Goldowsky was induced to transfer his activities to Providence and to establish his own private agency.

In a memoir written for the *Rhode Island Jewish Historical Notes*, Dr. Goldowsky cites his own involvement in two of his father's cases: "For one summer when I was in college, he permitted me to participate in the surveillance of two loan sharks. I actually spotted a suspicious jewelry worker doing business with one of them, but the matter was not pursued to the point of incriminating evidence and prosecution. On another case I drove the family car during an after-dark investigation in a nearby Massachusetts community. We were challenged by the local police whose

suspicions made an end to our endeavor, and terminated the only serious investigation in which I was personally involved."

Dr. Goldowsky's involvement in medical journalism was a substantially more serious enterprise and certainly more enduring. His initial scholarly contribution to the *Rhode Island Medical Journal* is found in the 1937 publication of his paper on peripheral arterial disease. Additional contributions by Goldowsky followed on various diseases of peripheral veins as well as a series of editorials on diverse subjects submitted during the tenure of Peter P. Chace as Editor-in-Chief (1942-1956). Chace, incidentally, was the author of an extremely popular editorial column in the *Providence Journal* entitled, "You and Your Health." When Chace's successor, Dr. John Donnelly, died in 1960, Dr. Goldowsky was offered the position of Editor-in-Chief, a position that he has held without interruption for over a quarter century.

The *Journal* has been witness to a number of dramatic changes during these past 26 years including the addition of a four page monthly newsletter about the Society's activities, a regular monthly forum for the Society's President, semiannual calendar of continuing medical education events taking place within the greater Rhode Island community, and the occasional publication of notable orations which had been presented in the hospitals of Rhode Island. Under the direction of the Society's Publications Committee, Dr. Goldowsky and the *Journal* staff have provided valuable services to potential authors in the Rhode Island medical community by aiding them in producing readable manuscripts. While other publications can afford the luxury of sending out uninformative rejection slips, the *Journal* often tempers its rejections with detailed instructions for suggested revisions.

During these past 26 years the *Journal* has also seen the establishment of an accredited medical school in Rhode Island; and from its beginnings, the school was materially aided and encouraged by Dr. Goldowsky and the *Journal*. Indeed, during the 1970's, the June issue of the *Journal* traditionally described and portrayed each Brown University medical graduate, thus forming a bridge to reconcile the differences between academic medicine and the more pragmatic practice of medicine. Beginning with the inaugural class of 58 M.D.'s in 1975, many of the men and women who have graduated from Brown's Program in Medicine have now established their professional roots in virtually every one of the major communities in Rhode Island. Dr. Goldowsky has also encouraged the medical students at Brown to contribute learned essays to the *Journal*, and these have been periodically published.

Under Dr. Goldowsky's editorial leadership, the *Journal* has provided its professional readers with issues devoted solely to issues of current concern such as teenage suicide, Alzheimer's disease, Hospice, the role of hospital chaplaincy, Parkinson's disease, Acquired Immune Deficiency Syndrome and sports injury.

Dr. Goldowsky has been instrumental in stabilizing the *Journal* through the securing of financial backing by means of enhanced advertising revenue. As a member of the Board of Directors of the state Medical Journal Advertising Bureau, he has been of material help in obtaining advertisement from leading pharmaceutical houses and other national sources. Under his guidance, the *Journal* staff has mounted an aggressive advertising campaign that has generated a substantial increase in the revenue from local businesses and professionals. While readers may skim over advertisements, and perhaps regard them as unnecessary filler, they nevertheless remain the essential lifeblood of all publications, including the *Journal*.

Amongst his friends and colleagues, Dr. Goldowsky is perhaps best known for his impassioned interest in Rhode Island history. He has served on the League of Rhode Island Historical Societies, was past President of the Rhode Island Jewish Historical Association, was past Editor of Rhode Island's Jewish Historical Notes and has written the chapter dealing with the period of 1812-1862 in the History of the Rhode Island Medical Society.

Dr. Goldowsky has had an enduring interest in the life of Usher Parsons, one of Rhode Island's most distinguished physicians. Parsons, who was born in 1788 and died in 1868, is the subject of Goldowsky's forthcoming biographic text soon to be published by the Francis A. Countway Library of Medicine. Born in Alfred, Maine, and descended from an impressive line of distinguished lawyers, clergy, physicians and statesmen, Parsons was destined for a life filled with cultural, scientific and professional pursuits. Parsons' ideas concerning medical education appear to be a century in advance of his time; he felt, for example, that ten years of study is a necessary interval in order to prepare a student properly for a medical career. His service as a surgeon in the Battle of Lake Erie is outlined in the chapter from Goldowsky's biography which

appears in this issue of the *Journal*. As Professor of Anatomy at Brown University medical school, Parsons had a number of disagreements with the Rhode Island Medical Society but these were not sufficient to prevent him from serving as the President of the Society from 1837 to 1840. In 1858, Parsons served on a group which was the predecessor of the Society's current Publications Committee. That distinguished group also included Isaac Ray and George L. Collins who were collectively charged with, "publishing such papers, biographical or medical, now in the archives of the Society as might be considered worthy." The resultant publication, issued under the title, "Sketches of Rhode Island Physicians Deceased to 1950," became the first issue of volume one of the Rhode Island Medical Society, the linear ancestor of the *Rhode Island Medical Journal*.

Dr. Goldowsky's contributions to the advancement of our profession have been immense. His tireless efforts during these many decades of tenure as Editor-in-Chief of this *Journal* have served to educate us on a multitude of issues ranging from ethical concerns and advances in medical knowledge, to the practical political decisions that impinge upon the practice of medicine.

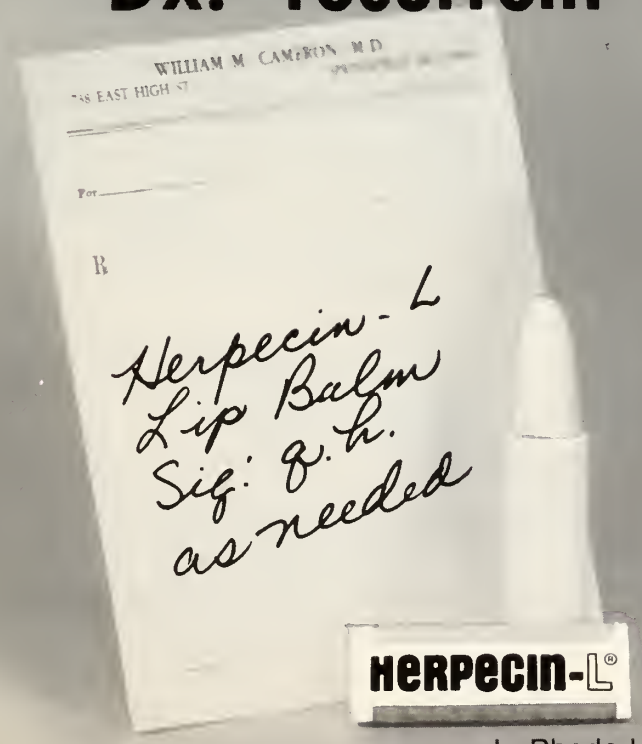
Through much of his professional career, Seebert Goldowsky admired the writings of William Osler. It is therefore appropriate to remember Osler's farewell address to American and Canadian medical students when he quoted the words of Cowper:

> Knowledge and wisdom, far from being one,
> Have oft-times no connexion. Knowledge dwells
> In heads replete with thoughts of other men;
> Wisdom in minds attentive to their own.
> Knowledge is proud that he is learned so much;
> Wisdom is humble that he knows no more.

Through the pages of this *Journal*, our Seebert Goldowsky has truly provided us with measures both of knowledge and wisdom for which we are all grateful. We of the Society and his colleagues wish him many further years of good health, professional creativity and, above all, *aequanimitas*.

Wendy Smith
Stanley M. Aronson, M.D.

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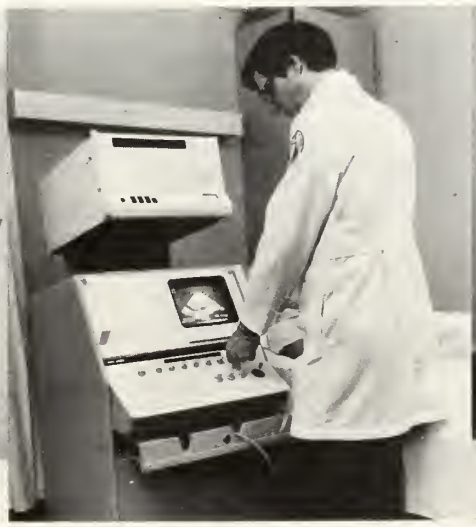
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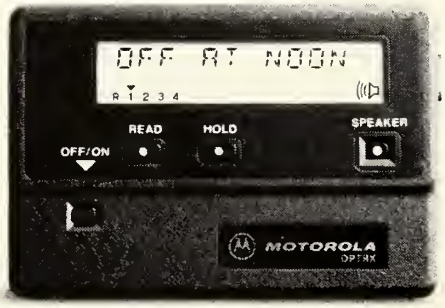
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PRESIDENT'S PAGE

Planning — The Way to the Future



Peter D. T. Clarisse, MD

Twenty-five years ago our profession functioned with little regulation or outside intervention. Physicians devoted virtually all of their time and energies to the practice of medicine. Today we have become highly regulated and subjected to distractions, many of which seemingly do not relate to providing quality health care.

The Rhode Island Medical Society (RIMS) had to make adjustments during this time. While we continue to be the primary advocate for Rhode Island physicians and patients, we also offer the other services which a professional association should provide. However, at some point a re-evaluation of our activities and goals becomes necessary. We have to determine the services that RIMS should be providing, the services that are better left for others to provide, and the status of our resources. In a nutshell it is time to set priorities.

I called a special two-day conference on October 17 and 18, to allow the RIMS Council an in-depth look at the Society. Invited to guide the conference was Bruce Balfe, Vice President for Issues Planning and Management of the American Medical Association (AMA).

The Balfe conference concentrated its evaluation on three central issues. First, how has the practice of medicine changed over the last 25 years? Second, how have physician's needs changed? Third, how has the Society responded to these changes, and what further adjustments are necessary?

When comparing our profession of 25 years ago to that of today, the obvious difference is that physicians used to be more in control of their practice. Practicing medicine now is much more complex because of third-party payers and federal and state regulations. We must devote a significant amount of our time to legal matters, public relations, fiscal management, administration, and personnel supervision.

Relationships with our patients have also changed. Within the development of a high degree of specialization, it is often difficult to build close relationships when we see many patients on a short-term basis only. The breaking down of bonds between patients and doctors is certainly one of the prime factors in today's malpractice climate.

The net effect of these developments is a change in the services that doctors find essential. We have always required a great deal of scientific information. In days past the Society provided it through its library holdings and regular scientific sessions. Now this information is readily available from university and hospital libraries, continuing medical education courses, specialty journals, and other sources. However, a growing demand exists for adequate information relating to legislative, judicial, regulatory, and insurance issues. Much of this information concerns panels, committees, commissions, and other bodies that make decisions which affect our practices. Our concerns must be heard, and sophisticated representation is imperative.

Lobbying is an integral and fundamental part of the legislative process at all levels of govern-

ment, and doctors must have organized lobbying efforts. Our positions must be articulated at public hearings and legislative committee meetings. In addition, many laws, regulations, and insurance matters eventually find their way into the court system. Physicians must have advocates presenting their case and offering sound legal advice.

Finally, it is necessary for doctors to assure that the highest quality of health care is provided to our patients. Our profession would be remiss if we did not establish mechanisms to sustain the highest professional standards.

Regarding how RIMS has responded to the changing needs of its members, it continues to be the primary advocate of Rhode Island patients and physicians. The Society took the lead in the medical liability crisis, introducing legislation and pushing for tort reform in coalitions, commissions, and committees. The $100 special assessment was passed to fund an aggressive public relations, lobbying, and legal compaign.

Your investment is paying off, and our presence is starting to be felt. We have achieved a start towards tort reform, and a year's freeze on premium increases. The Society blocked a proposed surcharge sought by the Department of Business Regulation (DBR) on all medical malpractice insurance premiums. The successful suit saved each Rhode Island physician, on average, $1300 this year.

We are continuing to work for a more satisfactory solution. RIMS is currently participating in three new forums addressing the malpractice crisis: the Governor's commission on liability, the special General Assembly commission to study the Joint Underwriting Association, and a coalition with business and civic leaders.

More work remains to be done. The House of Delegates recently increased annual dues by $100 starting in 1987 to support these efforts. The special assessment in 1985 has proved to be an astute investment, and the dues increase, we are confident, will lead to further gains in the future.

To promote the highest quality of health care, the Society maintains several peer review committees and educational functions. RIMS also sponsors public service activities. An example is an advertisement which we recently placed in *The Providence Journal Bulletin* offering assistance to the public in facing the highly competitive and confusing health insurance market. These public service activities will be continued and increased in accordance with the public's needs.

To meet the growing demand for socio-economic information, we are planning a new format for the Newsletter. The present production schedule for the Newsletter included in the *Journal* is six weeks. Frequently items have lost their timeliness. By separating the Newsletter from the *Journal* and printing it locally, we hope to have a new communications mechanism with the capability of putting today's news in your hands tomorrow.

Many concerns were raised at the Balfe conference which I intend to address during the second half of my term as your President. These relate primarily to the fact that many of the Society's activities were designed for a different era.

The usefulness of the RIMS Library and *Journal* have been repeatedly questioned. When these activities were first started the Society was the foremost medical scientific research resource in the state. However, other sources today include Brown University's medical library, the libraries of our hospitals, and the many specialty journals. A close evaluation of our options during the coming months is necessary in order to determine the most effective use of our assets.

The Balfe conference noted that while our membership base is strong, the low level of participation and commitment is disturbing. It is axiomatic that our patients have the first call on our time. Yet, we must find time to support the Society in its legislative and regulatory responsibilities.

At a recent pre-election breakfast meeting with Governor DiPrete hosted by RIMS, the Governor was quite discerning when he observed that doctors are often perceived by the legislature as not involving themselves in most health-care issues. He encouraged our membership to become more active in these matters, because we have an extremely credible voice. The Governor asked for our input and indicated that the legislature welcomes our participation. And he noted that the larger the number of RIMS members in contact with the legislature the more effective our lobbying effort will be.

The Society has made several important adjustments in recent years. We are grateful to Bruce Balfe for focusing our attention on the need for further change. Now it is time for us to develop our long-range plan, so that we may function effectively in the 1980s and 1990s.

The time has come for us all to increase our support — both through active participation as well as financially. Your input regarding the direction of the Society is essential. Become active. Participate. You are the key.



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The Medical Odyssey of James Joyce

The Author of Ulysses *Exhibited a Considerable Interest in and Knowledge of Medicine*

Irving A. Beck, MD

Abstracted from presentations at the Maine Society for the History of Medicine May 4, 1985, and at the John Russell Bartlett Society, Brown University, November 14, 1985.

An exposition of almost any aspect of the relationships of the life of James Joyce to his writings encounters an embarrassment of riches — a superabundance of primary and secondary sources. As regards the latter, the flood of commentaries and critiques shows no signs of diminishing. In the 1982 *Modern Language Association International Bibliography,* Joyce is second only to Shakespeare in number of author citations, and those to *Ulysses* exceeded only by *Don Quixote.*

This essay presents a modicum of biographical data and literary references that emphasize those that relate to medicine.

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Best known for his revolutionary novel *Ulysses,* the life of James Augustine Joyce (he later dropped the middle name) was an odyssey in the Homeric sense — a long wandering with many turns and returns, adverse encounters, and changes in fortune. Born in Dublin, Ireland on February 2, 1882, his Ithaca was Zurich, where, during World War II, he found refuge and his final resting place.

Early Years

His father, John Stanislaus Joyce, like his son, originally contemplated a medical career. He had attended medical school in Cork, but failed to complete his studies and was expelled because of riotous behavior. His son, Stanislaus, later commented that many lives had been saved thereby. John was an attractive but feckless individual whose inability to make a living and addition to alcohol caused the family to sink from modest affluence into genteel and finally dismal poverty.

James began his formal education as a relatively young student at the Jesuit Boys Boarding School, Clongowes Wood College. He did well scholastically and became devoted to religious activities. His withdrawal from Clongowes Wood was necessitated by the decreasing financial resources of the family. These youthful experiences are recorded in his semi-autobiographical novel, *A Portrait of the Artist as a Young Man.*

He subsequently attended Belvedere College, a Catholic Day School in Dublin, where he was elected perfect of the Sodality of the Blessed Virgin. In 1898, he entered the University College of Dublin from which he graduated in 1902. At that time, he had become estranged from, and then actually antagonistic toward Catholicism. In 1904, he left Ireland in a self-imposed exile on the continent with his companion, Nora Barnacle, whom he eventually married in a civil ceremony in 1931. His subsequent geographic wanderings included sojourns in, and returns to Pola on the Adriatic, Trieste, Rome, Zurich, Paris, and London, and brief visits to other locations in England, France, and Switzerland. He returned only twice to Ireland.

He never supported himself and his family adequately by his writing, teaching, and other literary chores, and depended upon contributions from his brother, friends, and a series of literary patrons. His four major works were *Dubliners* (1914), a collection of short stories, and the novels, *A Portrait of the Artist as a Young Man* (1916), *Ulysses* (1922), and *Finnegans Wake* (1939). In addition, he composed poetry, wrote literary criticism, and one play, "Exiles." His letters, which are voluminous, have appeared in various compilations, and some have not as yet been publicly revealed. These have provided a mine of material, much of it painfully self-revealing, for his biographers and critics. He was a talented singer and, in his early days, performed professionally.

Joyce's personal medical Odyssey may be divided into his early ambition to become a physician, his social and professional contacts with the medical profession, his health problems, and those of his family. In the words of one biographer, his adult life was "one protracted illness." His writings are replete with medical allusions and associations. There are enough medically related materials in these and in Joyce's own medical history to fill a book, and, indeed, they have! Doctor J. B. Lyons, a neurologist in Dublin, himself a novelist, critic, and biographer, published a monograph titled *James Joyce and Medicine* in 1973. Further contributions relating to medical aspects of Joyce steadily continue to appear. Thus, in 1975 the Royal College of Physicians of London displayed an exhibit (with a catalogue) of Joyceiana with especial emphasis on Joyce's own medical history. This was titled "My Impossible Health or the Case of James Joyce."

This continuing profusion of articles has justified his prediction after the appearance of *Ulysses:* "I've put in so many enigmas and puzzles that it will keep the professors busy for centuries arguing over what I meant." This has been further stimulated by the appearance on Bloomsday 1984 of the definitive text of *Ulysses,* published under the editorship of Hans Gabler correcting some 5000 textual errors — most of them minor. No doubt, reinterpreted passages will result in a fresh spate of literary commentaries and PhD theses by the "professors"!

Throughout his career, Joyce had various relationships with physicians. During his youth, this was primarily as a "medical student's pal" (Gogarty). He associated with them socially and as a quasi-"medical" at hospitals. This is reflected in Stephen's participation in the "Oxen of the Sun" episode in *Ulysses* (v.i). During the latter part of his career, his contacts were primarily as a patient for his multiple ailments. He visited a series of psychiatrists in the process of seeking medical help for his schizophrenic daughter, Lucia.

Beginnings of Literary Career

One of his first literary efforts (1900) was an Ibsenian play, with a doctor as the hero, titled *A Brilliant Career.* This he destroyed and it is now known only from his letters and his brother Stanislaus' memoir. During his final year at University College (autumn 1902), he decided to study medicine. He was not fired by any humanitarian ideals, but frankly stated that he intended to make enough money in a number of years sufficient to allow him to devote the rest of his life to literature. There was probably another motive which is revealed in the Telemachus episode of *Ulysses.* Physicians, at least at that time, enjoyed a certain aura which commanded respect from the laity. This episode takes place in the Martello Tower in which Stephen Dedalus (Joyce) is living with Malachi (Buck) Mulligan (Oliver St John Gogarty) a "medical," and an Englishman named Haines. An old lady delivers milk to them and Buck Mulligan with the pompous authority often assumed by medical students proceeds to give her a lecture on its nutritional value: "Stephen listened in scornful silence." He ruminates, "She bows her old head to a voice that speaks to her loudly, her bone setter the medicine man. Me she slights." While at that time the embittered Joyce had given up his hope of becoming a physician, he obviously retained an envy of those who had "made it." As late as 1920, he wondered if he had not made a mistake to abandon medicine.

He did actually enroll in the medical program of University College and may have attended some medical lectures in the fall of 1902. Later

he went on to Paris with the intention of enrolling in the Medical School at the University of Paris. To accomplish this, he conducted a preliminary campaign of sponging on friends and acquaintances, a practice which he continued throughout his career. It is questionable how much exposure he had to medical studies in Paris, and, in any event, he returned to Ireland in the spring of 1903 in response to a message that his mother was dying. In the fall of 1903, he re-entered the Medical School at University College, but soon abandoned it. He resumed his participation in the raffish life of the medical students. The latter included his erstwhile friend Gogarty who was able to do what Joyce had not, namely to go on to a career notable in both medicine and literature (and later in politics).

Gogarty later recorded some of his experiences with Joyce. A notable observation was his comment about Joyce during their joint sojourn in the Tower: "His father was an alcoholic, an old alcoholic wag. His mother was a naked nerve. . . . I did my living best to cheer him and to make those thin lips of his cream in a smile. . . . I should have known better for I was studying abnormal psychology. . . . It is one thing to study lunacy in an asylum, another thing to recognize it in a friend. Had I succeeded in ministering to a mind diseased Joyce would not be the greatest schizophrene who ever wrote this side of a mental hospital. He would never have been famous and Dublin would have been less." The question of Joyce's mental status has been explored extensively in the psychiatric literature and will be later commented upon.

Ulysses

The literary fame of Joyce stems primarily from his novel *Ulysses*. After several years of gestation and prior publication of portions, the book was finally rushed into print in Paris under the aegis of Sylvia Beach on February 2, 1922, his 40th birthday. The timing was not coincidental as Joyce had a life-long superstition about dates and their mystical significance. This innovative, controversial novel, its revolutionary varying styles, the frequent use of the interior monologue (the nonverbalized thoughts of the subject), language that neglected punctuation and was deliberately obscure and frequently coarse, had a smashing impact on English literature. In the words of the poet, T. S. Eliot, *Ulysses* had "killed the 19th Century and exposed the futility of all styles." Ernest Hemingway called it a "most goddamn wonderful book." Such opinions were by no means unanimous. One of the politer comments was that of Virginia Woolf that "it was underbred and the book . . . of a queasy undergraduate scratching his pimples." Its explicit language offended many, and it was officially banned in this country and in England. It was not until the landmark decision by Federal Judge John M. Woolsey, December 6, 1933, which concluded "that though the effect of 'Ulysses' on the reader undoubtedly is somewhat emetic, nowhere does it tend to be aphrodisiac. 'Ulysses' may therefore be admitted to the United States."

The central theme of the novel is a one-day journey through Dublin on June 16, 1904 of one Leopold Bloom, an advertising solicitor of Jewish descent. This date has now become known as Bloomsday, and the anniversary regularly celebrated by Joyceans. The date was presumably selected by Joyce because it was his first walking out with Nora. The journey is interwoven with encounters of a host of other characters, most of them based on actual individuals, in a series of episodes, each with its peculiar style and related only in a metaphorical sense to those encountered by the Homeric hero Ulysses. Sometimes the relationship to the classical paradigm is not only obscure but paradoxical. Thus, the final episode, *Penelope*, which in the classical saga marks the return of Ulysses to his ever-faithful wife, in Joyce's version depicts the ruminations in earthy language of Leopold's wife, Molly, dwelling upon her fantasies, and possible realities, of past love affairs, and of her current adulterous affair with one Blazes Boylan.

Ulysses abounds in scattered medical allusions. A mere listing would exceed the capacity of this presentation. The episode *Oxen of the Sun* is, however, devoted in its entirety to one unifying biological theme — human reproduction in all its aspects — and will therefore be considered in some detail.

The title derives from the episode in the Homeric legend wherein the starving sailors of Ulysses, ignoring his warning, slaughtered and consumed the Sacred Oxen on the Isle of the Sun. They are in turn drowned when their ship is struck by a thunderbolt, and only Ulysses is spared. The Oxen of the Sun are symbols of fertility, hence the rather tenuous connection with Joyce's theme.

In preparation for its composition, Joyce studied embryology, and his notes contain elaborate sketches illustrating fetal development. The episode takes place in the Holles Street Maternity Hospital. In his wanderings through Dublin,

Bloom had visited the hospital to inquire about Mrs Mina Purefoy, who is still in labor after three days. He is invited to join a party of interns and medical students including their "pal" Stephen Dedalus in their commons. They are a noisy, bawdy, convivial lot, and their far-ranging conversation, rich in obscenities, covers diverse topics, but all central to the theme of reproduction. These include birth control, sexual practices, abortion, adultery and the ethical position of the Church on these and related topics. Buck Mulligan makes a prescient proposal, a sperm bank for the infertile, with himself as an *in vivo* donor. The behavior of the medicals is generally distasteful, and only Bloom is portrayed as being sympathetic to the parturient patient. Mrs Purefoy finally delivers, to his great relief. Bloom is disturbed by the flippancy of the doctors in training and is puzzled that "the mere acquisition of academic title should suffice to transform in a pinch of time these votaries of levity into . . . practitioners of an art . . . esteemed the noblest."

This episode also develops elaborate parallels between the development of the fetus and that of the English language in a series of parodies of prose style. These range from the Anglo-Saxon to the slang of the 20th Century.

In addition to *Ulysses*, items illustrating Joyce's interest and knowledge of medicine appear in the *Portrait*, *Dubliners* and *Finnegans Wake*. The last, for example, contains a reference (in Joycean neologisms) to the threat that this "Ogrey Osler will ox-maul us all." This is a reference to the *Fixed Period* episode in 1905 wherein Sir William Osler, somewhat unjustly, was villified as advocating euthanasia for men when they reached age 60.

Personal Medical History

Joyce's own medical history is of considerable interest particularly as regards its influence upon his writings. He had numerous episodes of urethritis beginning at least by 1904. These may have been gonorrheal or, in light of present knowledge, also chlamydial. In 1907, he was hospitalized for two and one-half months in Trieste with "rheumatic fever" which he attributed to lying in gutters. More specific details of this illness are not noted, but his autopsy revealed a normal heart. It would therefore appear that, if this were truly rheumatic fever, he had sustained no residual valvulitis. His eye problem appears to have begun in 1909 as an iritis preceded by sciatica. Iridocyclitis attributed to a malarial attack recurred in 1915. In 1917, he had further complications with synechiae and glaucoma. He consulted a series of distingnished European ophthalmologists. Nor did he want for nonmedical advisers, one of whom was Ezra Pound. He apparently had received some coaching in optics, for he surmised Joyce had astigmatism and recommended a trial of cylinder lenses. He also suggested that Joyce should visit an osteopath. He knew "an increasing number of people" whom "regular physicians have bungled, who have been cured and renovated by having a vertebra set right side np."

His subsequent eye history is one long litany of repeated bouts of iritis and operations including iridectomies, sphincterectomies, capsulotomy, and cataract surgery. The final result was near-blindness. Dental infections occasioned much suffering, from his youth on, with frequent dental surgery.

The visual problems probably affected the entire tenor of his writings. Joyce appears to have dealt "principally in auditory sensation" in his later phase (Edmund Wilson). Sylvia Beach noted that "as his sight diminished, his hearing developed so that he lived more and more in a world of sounds, so *Finnegans Wake* to be comprehensible must be heard by the reader."

There has been considerable speculation as to the etiology of the chronic uveitis. Doctor Lyons has marshaled the evidence for the condition being one of the manifestations of Reiter's syndrome. Certainly his history of "rheumatism" including spinal arthritis and recurrent bouts of urethritis tend to favor this diagnosis, although he did not have the frequent skin manifestation of keratoderma blenorrhagica. A recent biography (Davies) revives the theory that it was a manifestation of congenital syphilis. This appears unlikely, in spite of the fact that his father was said to have had a syphilitic chancre. The ophthalmologists of the time were certainly familiar with ocular syphilis, particularly in its congenital form, more prevalent then than now. The Wasserman test was already in use, and the antisyphilitic drug salvarsan was available. There is no record of its use, although he mentions receiving arsenic and phosphorus injections; it is likely that these were for their so-called tonic effect. He did not have the corneal involvement that occurs in congenital syphilitic keratitis. Its absence (it usually has developed by age 13) is against the diagnosis of congenital syphilis.

Reiter's syndrome can explain the entire clinical history, particularly the stubborness of the iridocyclitis, the prognosis of which is worse than

that of the other systemic conditions with which it may be associated.

As mentioned previously, Joyce's own psychiatric status has been the subject of considerable retrospective analysis. This has included even those characters which were the creations of his mind. A recent doctoral dissertation apparently managed to include both, being titled "James Joyce from Stephen to Bloom, a Psychoanalytic Study." Doctor Karl Jung, whom Joyce had consulted for his hebephrenic daughter, commented that Lucia and her father were like two people going to the bottom of a river, one falling and the other diving (the latter obviously referring to James and implying that he was at least capable of rising to the surface). Doctor N. J. C. Andreasen, a critic with doctorates in both psychiatry and medicine, has pointed out that Joyce had many symptoms compatible with a schizoid personality. These included aloofness, sensitivity and superstitiousness, egocentricity, disdain for conventional morality, anger toward humanity in general and those who crossed him in particular. One also recalls the observations of Gogarty.

This assessment was vigorously rebutted by Doctor Lyons in an exchange of letters with Doctor Andreasen. The polemic does not appear to have been resolved, and a parting shot from Doctor Andreasen stated that Joyceans are "a devoted and militant group" (and possessed of) "apostolic fervor" which clouds their "objectivity."

His periodic episodes of "nervous collapse" may well have been reactive depressions. He drank heavily from at least 1904, but tapered off later in life. Ellman felt he drank at night to relax and forget his troubles, but Jung attributed his habit to an attempt to control his psychotic tendencies. The habit may have been associated with his gastrointestinal symptoms. The autopsy revealed a normal liver and spleen, so he appears to have escaped alcoholic cirrhosis.

As with many people who also have chronic organic illnesses, Joyce had a tendency to exaggerate his symptoms, to worry a great deal about his health, and to solicit and welcome sympathy. Numerous episodes have been recorded.

Meeting With Proust

In 1922 in Paris there was a memorable meeting between him and Marcel Proust. Like Joyce, Proust was a hypochondriac with multiple ailments. These included asthma, and an extreme sensitivity to sounds so that he wrote in a cork-lined room. On May 18, 1922, the followers of each of these literary giants arranged a meeting in the hope of witnessing some witty gems of brilliant conversation. Doctor William Carlos Williams, a practicing physician and also one of the most distinguished American poets and authors of this century, related one version of the encounter (there are several) in his autobiography: "Two chairs were placed side by side in the middle of the room. There the heroes were seated while the partisans arranged themselved right and left waiting for the wits to sparkle and flash. Joyce said, 'I've headaches everyday. My eyes are terrible.' Proust replied, 'My poor stomach. What am I going to do? It is killing me. In fact, I must leave at once.' 'I am in the same situation' replied Joyce. 'Goodby.'" Doctor Williams also records his own experiences with Joyce in his Paris visit of 1924, and comments on oddities of his behavior.

It is interesting to speculate what kind of physician Joyce would have been had he persisted in his ambition. Doctor Lyons thought he might have been a good one because of his powers of observation, but, on the other hand, he did also indicate that Joyce's distorted interpretation of what he saw indicated a flawed psychological makeup.

Edna O'Brien, a prolific Irish writer, discussing the same subject noted that "no two occupations are closer than that of doctor and novelist. . . . Had he qualified he would have been bound to have gone on and been a gynecologist." This conclusion appears somewhat odd, since in a later article Ms O'Brien commented on Joyce's intense sexual fetishisms which included an obsession with women's underclothing, his practice of carrying a miniature pair of women's drawers in his pocket, and other female sexual preoccupations. Ms O'Brien states these were "spermic titivation." This seems hardly a personality for a gynecologist — at least for one who wishes to stay out of trouble.

Joyce had an obsession about syphilis and stated that western civilization (which he altered to syphilization) suffered from a metaphoric syphilis. Some authors have regarded syphilis as a major theme in Joyce's writings, mentioning that his frequent use of the letter 's' (including the first and last words in "Ulysses") was a code symbol for syphilis. (Actually more words in English start with 's' than with any other letter.)

Final Episode

The events leading to Joyce's death have been graphically reconstructed by Lyons. He had had a chronic history of gastrointestinal complaints

which, however, bore little resemblance to the symptom-pattern of peptic ulcer. A stomach x-ray study at one time had been reported as negative. His complaints appear to have a relationship to periods of emotional instability. However, the final episode, which began on January 10, 1941, was obviously different, and diagnosis may have been masked by a narcotic. Eventually it was clear that he had had a perforation of a peptic ulcer with peritonitis. He was operated upon, but developed postoperative bleeding, failed to rally, and died. Autopsy confirmed the presence of the perforated ulcer and peritonitis, but there was secondary hemorrhage from a second, shallow ulcer of the duodenum.

Joyce and his writings continue to be topics for medical contributions. Two examples appeared recently in the *British Medical Journal*. A symposium on tuberculosis in Dublin in 1982 commemorated the centenary of Koch's discovery of the tubercle bacillus, which also coincided with the observation of the centenary of the birth of Joyce. A "lost manuscript" by the Master was read for the guests by the spokesman, Doctor John Crofton. Titled *Tubercles Wake or Acabacillis Porelittlefella*, it had recently been recovered from the litter bin of a local pub. Written in the characteristic lingo of the *Wake*, it is accompanied by an exegesis by the Professor of Biconvoluted Prosology *(sic)* at Oxford. The full text appears in the *Journal* article.

An essay relating the experiences of a medical student at Trinity College, Dublin, "on the same side of the desk as my mentors" titled "Ongoing Interaction and the Moon Oxen: Observations on a Week's General Practice in the Year of Joyce's Centenary" appeared in the Christmas issue of the *Journal* in 1982. The style, including the absence of punctuation and with the interpolated 'yes' is that of the soliloquy of Molly Bloom in the *Penelope* episode. The substance is a disillusioned commentary on the realities of office medical care in the government medical service.

Footnotes indicate that this article had been submitted as "part of the requirements for the final degree of MB and BCh." His recorded degrees reveal that the candidate was successful.

. . . only in Ireland!

Acknowledgment

Grateful acknowledgement is made to Mrs Grace Varghese and Ms Marion Sabella for assistance with the bibliography, to Robert L. Bahr, MD and Stephen R. Kaplan, MD for retrospective diagnoses, and to Mrs Sandra Ells-Bush for patient typing and re-typing of multiple manuscript drafts.

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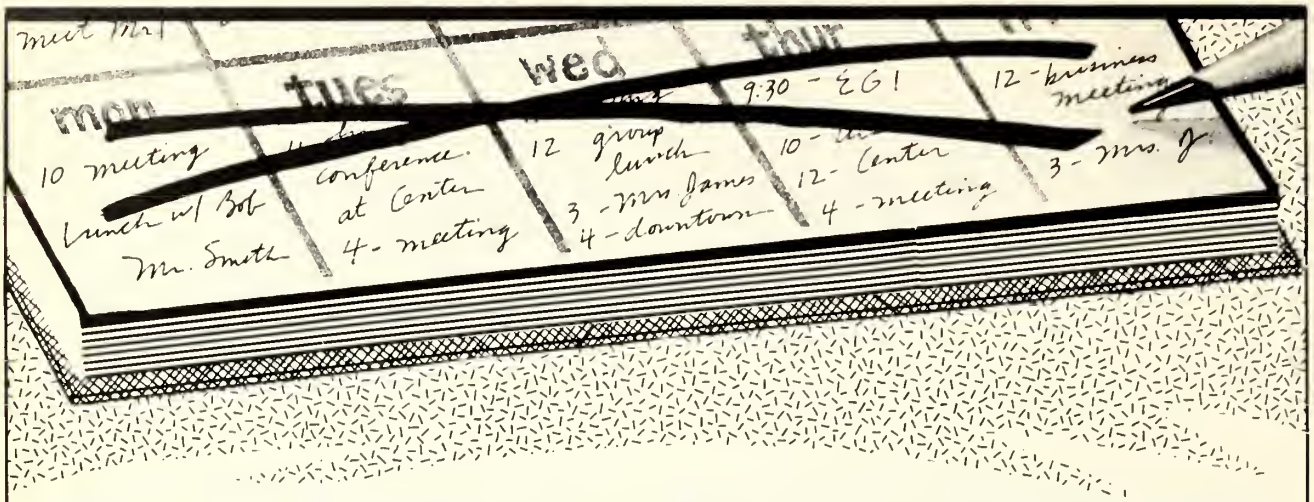
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Usher Parsons: The Battle of Lake Erie

The Story of the Great Battle in 1813 from the Diaries of the Medical Officer Aboard the Flagship Lawrence

Seebert J. Goldowsky, MD

This paper is a chapter from a forthcoming book titled "Yankee Surgeon: Usher Parsons, MD, 1788-1868," to be published by the Countway Library at the Harvard Medical School with also the imprimatur of the Rhode Island Publication Society. Parsons was Professor of Anatomy and Surgery at the Medical School in Brown University from 1822 to 1827. He was the brother-in-law of Doctor Oliver Wendall Holmes, Vice President of the American Medical Association, and a founder of the Rhode Island Hospital.

Usher's own vivid story[1] of the strategic Battle of Lake Erie was written almost twenty-nine years after the event. Based as it was on his own diaries and his sharp memory of his personal experiences, it has stood the test of time for accuracy. Such standard contemporary accounts as that of historians George Bancroft,[2] Henry Barton Dawson,[3] John Benson Lossing,[4] and Alexander Slidell Mackenzie, Perry's biographer,[5] borrowed from it freely.[6] Usher, the sole medical officer available for duty during the battle, was stationed aboard the flagship *Lawrence*. This is his account of the battle:[7]

> [On] the evening of the 9th of September [1813] . . . we anchored in Put-in-Bay. On the following morning at sunrise there was a cry from the masthead, "sail oh!" All hands sprang from their berths, and ere we could dress and reach the decks the cry was repeated again and again, until six sail were thus announced. Signal was made to the fleet, "Enemy in sight! Get under way!" and the hoarse voice and shrill pipe of the boatswain resounded through all the ships, "all hands up anchor."
>
> The wind at this time was from the southwest, light and baffling, which prevented our weathering the island in our way, and it continued so until ten o'clock [a.m.], when it veered to the southeast, which enabled us to clear the island [South Bass Island, the site of Put-in-Bay], and stand out upon the lake. We now discovered the English squadron, five or six miles to the leeward, hove to in a line, and equidistant about a half cable's length. The vessels were freshly painted, and their red ensigns gently unfolding to the breeze, they made a very gallant appearance. [It was now a "clear pleasant day"].[8] Our squadron bore down to engage them, with the wind on our larboard quarter. . . .
>
> The Commodore next produced the burgee, or fighting flag, hitherto concealed in the ship. It was inscribed with large white letters upon a blue ground, that could be read throughout the fleet, "DON'T GIVE UP THE SHIP" — the last words of the expiring Lawrence and now to be hoisted at the masthead of the flagship bearing his name.[9] A spirited appeal was made to the crew assembled upon the quarterdeck, who returned three cheers that were repeated along the whole line of our vessels, and up went the flag to the top of the foreroyal.
>
> The Commodore brought me a package of papers, having a piece of lead attached to them, and gave orders in the event of his falling, to throw the papers overboard; they were instructions from [the] Government, and letters from Mrs. Perry.
>
> The grog ration being served out, drums and fifes struck up the thrilling air, "all hands, all hands, to quarters," calling all to their respective stations. The Commodore was on the quarter deck, with two young officers, Thomas Breese and his own brother, Alexander Perry, whose duty it was to run with his

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orders to every part of the ship: for in the din and uproar of battle no officers can be heard ten feet off. The hatches were now closed excepting a small aperture ten inches square, through which powder cartridges were to be passed up from the magazine by boys nimble of foot during the battle, and through which light was admitted into the surgeon's room, where the wounded were to be brought. The floor of this apartment was on a level with the surface of the water outside, and consequently the wounded were as much exposed to the enemy's cannon balls as if they were on deck. Six men were directed to bring the wounded below, and to assist the surgeon in moving them.

Every preparation being made, and every man at his post, a profound silence reigned for more than one hour — the most trying part of the whole scene. It was like the stillness of the atmosphere that precedes the hurricane. The fleet moved on steadily till a quarter before Meridian [11:45 a.m.], when the awful suspense was relieved by a cannon shot aimed at us from the flagship *Detroit*, one mile distant. It was like an electric shock, and was soon followed by another. . . .

The Battle Rages

The enemy fire was concentrated on the flagship *Lawrence*. In time it was completely crippled and dropped astern, "a perfect wreck." Abandoning the *Lawrence*, Perry took off in a boat for the *Niagara*, which then became his flag-ship; the *Lawrence* hauled down her flag and ceased firing. The battle, however, progressed to complete victory for the Americans, with the action terminating at about 4:00 p.m. Usher's viewpoint is from his own battle station below deck:[10]

The wounded began to come down before the *Lawrence* opened her battery, and for one I felt impatient at the delay. In proper time, however, as it proved, the dogs of war were let loose from their leash, and it seemed as though heaven and earth were at loggerheads. For more than two long hours little could be heard but the deafening thunders of our broadsides, the crash of balls dashing through our timbers, and the shrieks of the wounded. These were brought down faster than I could attend to them, farther than to stay the bleeding, or support the shattered limbs with splints, and pass them forward upon the berth deck. Two or three were killed near me, after being wounded. . . .

Among those early brought down was Lieutenant Brooks, son of the late Governor Brooks of Massachusetts, a most accomplished gentleman and officer; and renowned for his personal beauty. A cannon-ball had struck him in the hip, he knew his doom, and inquired how long he should live; I told him a few hours. He inquired two or three times how the day was going, and expressed a hope that the Commodore would be spared. But newcomers from deck brought more and more dismal reports, until finally it was announced that we had struck [our flag]. In the lamentations of despair among the wounded, I lost sight of poor Brooks for a few minutes, but when the electrifying cry was heard that the enemy's two ships had struck, I rushed on deck to see if it were true, and then to poor Brooks to cheer him, but he was no more — he was too much exhausted by his wounds to survive the confusion that preceded this happy transition.

When the battle had raged an hour and a half, I heard a call for me at the small sky-light, and stepping toward it I saw it was the Commodore, whose countenance was as calm and placid as if on ordinary duty. "Doctor," said he, "send me one of your men," meaning one of the six that were to assist me, which was done instantly. In five minutes the call was repeated and obeyed, and at the seventh call I told him he had them all. He asked if any could pull a rope, when two or three of the wounded crawled upon deck to lend a feeble hand in pulling the last guns. When the battle was raging most severely, Midshipman Lamb came down with his arm badly fractured; I applied a splint and requested him to go forward and lie down; as he was leaving me, and while my hand was on him, a cannon-ball struck him in the side, and dashed him against the other side of the room, which instantly terminated his sufferings. Charles Pohig, a Narragansett Indian, who was badly wounded, suffered in the like manner.

Preoccupation with Casualties

The destruction and carnage aboard the *Lawrence* were appalling. In his report[10] to the Secretary of the Navy Perry stated: "Every brace and bow line being soon shot away she became unmanageable, notwithstanding the great exertions of her sailing-master. In this situation she sustained the action upwards of two hours within canister distance, until every gun was rendered useless, and the greater part of her crew either killed or wounded." Guns were dismounted; the killed and wounded were strewn about. But amidst these terrifying scenes the irrepressible Yanks saw things to smile about and ways to relieve the tension:[11]

There were other incidents that were less painful to witness. The Commodore's dog had secreted himself in the bottom of the closet containing all our crockery. A cannon-ball passed through the closet, and smashed crockery and door, covering the floor with fragments. The dog set up a barking protest against the right of such an invasion of his chosen retirement.

Lieut. Yarnell had his scalp badly torn, and came below with blood streaming over his face; some lint

was hastily applied and confined with a large bandanna, with directions to report himself for better dressing after the battle, and he insisted on returning to deck. The cannon-balls had knocked to pieces the hammocks stowed away on deck, and let loose their contents, which were reed or flag-tops, that floated in the air like feathers and gave the appearance of a snow-storm. These lighted upon Yarnell's head covered with blood, and on coming below with another injury, his bloody face covered with the cat tails made his head resemble that of a huge owl. Some of the wounded roared with laughter that the devil had come for us.

Concerning his management of the casualties Usher wrote:[12]

> [The ward-room] being only nine or ten feet square, this floor was soon covered, which made it necessary to pass the wounded out into another apartment, as fast as the bleeding could be stanched either by ligatures or tourniquet. Indeed this was all that was attempted for their benefit during the engagement, except that in some instances division was made of small portions of flesh, by which a dangling limb, that annoyed the patient, was hanging to the body . . . of about one hundred men reported fit for duty in the morning, twenty-one were found dead, and sixty-three wounded. The wounded arteries occupied my first attention, all which, except where amputation was required, were secure before dark. Having no assistant . . . I deemed it safer to deter amputation till morning, and in the meantime suffered the tourniquets to remain on the limbs. Nothing more was done through the night than to administer opiates and preserve shattered limbs in a uniform position.

Usher's diary contained a description of the action and this entry:

> . . . Slept but little, & dressed about one third, & secured with tourniquets such as bled copiously. During the action I cut off 6 legs in the cock-pit, which were very nearly divided by cannon-balls. Most of these numbered among the dead.

His formal account continues:[13]

> The hard fighting terminated about three o'clock. As the smoke cleared away the two fleets were found completely mingled, the small vessels having come up to the others. The shattered *Lawrence* lying to the windward was once more able to hoist her flag, which was cheered by a few feeble voices on board, making a melancholy sound compared with the boisterous cheers that preceded the battle.
>
> About four o'clock a boat was discovered approaching the *Lawrence*. Soon the Commodore was recognized in her . . . returning to resume command of his tattered ship, determined that the remnant of her crew should have the satisfaction of witnessing the formal surrender of the British officers. It was a time of conflicting emotions when he stepped upon the deck; the battle was won and he was safe, but the deck was slippery with blood, and strewn with the bodies of twenty officers and men, some of whom had sat at table with us at our last meal, and the ship resounded everywhere with the groans of the wounded. Those of us who were spared and able to walk, met him at the gangway to welcome him on board, but the salutation was a silent one on both sides; not a word could find utterance.
>
> And now the British officers arrived, one from each vessel to tender their submission, and with it their swords. When they had approached, picking their way among the wreck and carnage of the deck, they held their swords with the hilts toward Perry, and tendered them to his acceptance. With a dignified and solemn air, the most remote possible from any betrayal of exultation, and in a low tone of voice, he requested them to retain their side-arms, inquired with deep concern for Commodore Barclay and the wounded officers, tendering to them every comfort his ship afforded, and expressing his regret that he had not a spare medical officer to send them, adding that he had only one on duty for the fleet, [and he] had his hands full. . . .
>
> Those who were killed in the battle were committed to the deep at night-fall, the Episcopal service being read over them. . . .

Victory

Immediately following the cessation of hostilities Perry sent forward these historic communications famed for their terseness and dignity; the first to General Harrison, and the second to the Secretary of the Navy:[14]

> Dear General, —
>
> We have met the enemy, and they are ours. Two ships, two brigs, one schooner, and one sloop.
>
> Yours, with great respect and esteem,
>
> O. H. Perry.
>
> P.S. Send us some soldiers to take care of the prisoners who are more numerous than ourselves.
>
> * * *
>
> U.S. brig *Niagara*, off the westernmost Sister head of Lake Erie,
>
> Sept. 10, 1813, 4 p.m.
>
> Sir,
>
> It has pleased the Almighty to give to the arms of the United States a signal victory over their enemies on this lake. The British squadron, consisting of two ships, two brigs, one schooner, and one sloop, have this moment surrendered to the force under my command, after a sharp conflict.
>
> I have the honour to be, Sir, your obedient servant,
>
> O. H. Perry.

In his later report to the Secretary of the Navy, Perry noted:[15] "The *Lawrence* has been so entirely

cut up, it is absolutely necessary she should go into a safe harbor; I have therefore directed Lieut. Yarnell to proceed to Erie in her, with the wounded of the fleet and dismantle and get her over the bar as soon as possible."

Usher's diary resumes on the day following the battle:

> Saturday, September 11th. Very early I commenced operating. Found that four of those whose legs I amputated yesterday and laid on the berth deck were either afterwards killed in action or had died of their wounds. Before breakfast, had dressed one amputated leg, James Tompson of New York.
>
> After breakfast I amputated the leg of George Varnum of Wiscasset (Maine). In both these cases I deceived myself in applying the tourniquette not sufficiently taut and was compelled to turn it after having made the incisions. At ten o'clock I amputated the arm of James Moses of Falmouth (Maine). This case was a compound fracture of the humerus within 2 inches of the head. . . . Was unable to apply the tourniquet [because of the high level of the injury] and used compression on the first rib [to compress the subclavian artery]. After dividing the bone, found the artery had retracted so much that it was 15 minutes before I could arrive at it and then only by dissection. Secured it and made a tolerable covering.

The Aftermath

By seven o'clock he had completed all of the amputations. "The impatience of this class of the wounded," he wrote, "rendered it necessary to take them in the same succession in which they fell." He next attended to the compound and simple fractures, luxations, lacerations, and contusions in that order, "all which occupied my time till twelve o'clock at night." His account continues:[16]

> The day following [September 12] I visited the wounded of the *Niagara,* who had lain till that time, with their wounds undressed. I found the surgeon sick in bed, with hands too feeble to execute the dictates of a feeling heart. Twenty-one wounded were mustered, most of whom were taken on board the *Lawrence* and dressed, and afterwards such as were lying in like manner on board the small vessels. In the course of the evening the sick were prescribed for, which was the first attention I had been able to render them since the action.

In his entry for the day in his diary, he added:

> . . . Trepanned[17] John Newen, Quarter Master [and], removed several pieces of bone from the cerebrum, and a piece of leather hat. Found him sinking during the operation and dressed him immediately. A violent gale this day carried away all the masts of the *Detroit,* and the forward mizzen of the *Charlotte.* Funeral of the officers.

That evening, he later recalled,[18] "the officers of the small vessels came on board the *Lawrence* . . . and all of them, without exception, expressed but one opinion on the conduct of Elliott [Captain of the *Niagara*] in keeping out of the battle, that he held back more than two hours from engaging his antagonist the *Queen,* that when the *Lawrence* was much crippled and began to drop astern, the *Niagara* then came up abreast of her and the enemy, but far away outside, much farther from the *Lawrence* than the *Lawrence* was from the enemy." Elliott's tactics resulted later in a serious controversy between himself and Perry.

Usher described the officers' funeral in his history of the battle:[19]

> On the following morning [after the battle] the two fleets sailed into Put-in-Bay where the slain officers were buried on the shore. The scene was a solemn one. Equal respect was paid to the slain of the two fleets. Minute guns were fired from the fleet, a martial band preceded performing a funeral dirge, and the corpses were ranged in alternate order of American and British, and the procession followed in like order to the graves, where the funeral service was read.

Again from the diary:

> Monday 13th. Called the British surgeons in consultation today, viz. Dr. Young & Kennedy. Much pleased with them. Amputated limbs doing well. I am unable to attend the sick [presumably because of his own indisposition].
>
> Tuesday, Sept. 14. Wounded [i.e. the remainder] removed from the *Niagara* to the *Lawrence.* Officers from Gen. Harrison's army arrived on board. Dr. Crow was sent to assist me with the wounded from Harrison's army. Thursday 16th. Had not time before today to make out an official report of wounded. . . .
>
> Friday 17th. John Newen [his trephine case] died this morning & am unwell myself. We are just able to dispense with the wounded from morning 'til night. Amputated limbs doing extremely well. Saturday, Sept. 18th. Troops are coming in to Put-in-Bay from Sandusky, &c. Am very low spirited. Writing up the sick book. Sunday 19th. Unwell. Hardly able to attend duty. Monday 20. All impatient to sail. Market boat came along with fresh provisions from Cleveland & Sandusky. I bought for the wounded a barrel of pumpion *[sic]* pies.
>
> Tuesday, September 21st. Gen. Harrison on board. Dr. Martin, Surgeon General, consulted with me on all the desperate cases. We got under way for Erie and proceeded six miles. Wednesday 22. . . . [Two men] died with fever. Pleasant. Got under way at daylight, going 31 knots.

Letter to His Parents

On the same day he wrote his first letter to his parents since the great battle. It contained the earliest reference in Usher's own hand to Elliott's ambiguous conduct, which generated Elliott's later bitter conflict with Perry:[20]

> Before the arrival of this, an account of our victorious engagement with the British Squadron on this Lake will reach you. I can only add a few particulars. . . .

After briefly describing the action, he continued:

> It may seem mysterious to one how some of the other vessels could see us slaughtered in such a manner [and remain out of the action], but it is equally so to us. Nor can the commanders of some of them offer satisfactory reasons for remaining behind [i.e. Elliott and the Niagara]. Unfortunately for the wounded, the two Surgeons had been confined for some days with fever and could render them but little assistance. It however has operated in my favour, as I have had all the amputating to perform and it affords me the greatest pleasure to reflect that in no case have I failed of the best success. This has impressed the Commodore with so favourable opinion toward me that I have not the least doubt of his rendering me assistance to a better situation. He is the first warm friend I have met in the service capable of assisting me. I am now on my way in the *Lawrence* for Erie, having all the sick and wounded on board, and shall continue with them in the hospital 'til the most of them recover, and then intend to shape my course for Cape Home. Gen. Harrison was on board the *Lawrence* this morning,[21] and his army was on an island within half a mile of the vessel consisting of about 7,000. Since the loss of the British fleet the Indians have deserted Detroit after burning the place and (as is reported) massacring the inhabitants. I had some narrow escaped for my life during the action. Five cannon balls passed through the room in which I was attending to the wounded. Two that I had dressed and laid aside were afterwards killed during the action. The enemy's squadron mounted more guns than ours and carried at least one fourth more men. In the course of a year I hope to obtain a little prize money. I have enjoyed very bad health during the cruise and am reduced to a skeleton, and will never cross this or any other lake again.

Samuel, Usher's elder brother, was also in service on the Lakes, but was not mentioned in the diary. Usher, however, informed his family that "Samuel's steady and well." At high noon on the 23rd the *Lawrence* arrived at Erie and was greeted by a seventeen gun salute. The wounded were brought ashore and removed to the Courthouse hospital. Usher was now extremely busy caring for the casualties, but there was inevitable sadness. On the 28th Usher wrote in his diary: "Mr. Claxton very low." Thomas Claxton,[22] a midshipman whom Usher considered one of the most promising young officers, had received a mortal shoulder wound in the battle. His father, Doorkeeper of the United States House of Representatives, was unaware of the tragic event and had written from Washington relating news of the family and expressing pleasure at hearing that "you were well." Usher had the painful duty of informing Claxton's father of the sad death. Young Claxton died on October 8. He appears again in this story, but briefly, many years later.

On the 24th of September Usher learned from G. W. May[23] that the remittance of seventy-five dollars forwarded to Doctor Warren by "Mr. Farewell" in February had never arrived. May chided Usher for not sending the money by mail; or, if he had obtained the fellow's Christian name and address, he might be found and the money recovered. "Write to Dr. Warren," he advised, "and give him all the particulars." This was a payment to Doctor John Warren of Boston for Usher's earlier apprenticeship.

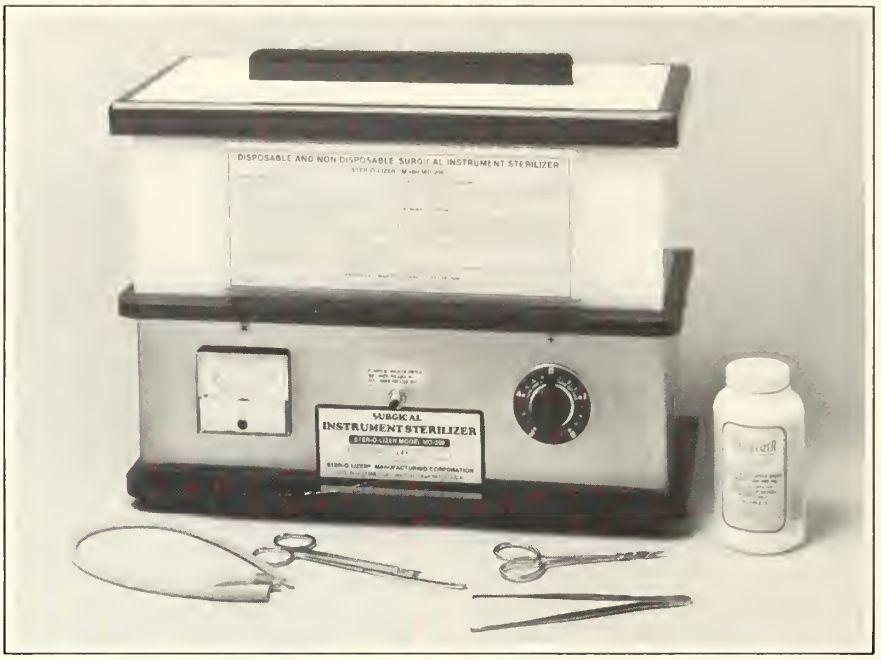
Usher found time for relaxation, tarried ashore with his new acquaintances, including a "Miss H," and visited the various ships for both professional and social reasons. On October 22 Commodore Perry and the defeated Commodore Robert Barclay arrived at Erie and were welcomed with a gun salute. That evening the houses and streets were illuminated, and a street procession was accompanied by the sound of cannon, "musick &c., &c."

Usher's finances were considerably bolstered by an "acceptance" from the Navy of $442 and later an additional unexpected $100. On the 13th he "took thorough rounds at the hospital" and later "operated on [one] George Platt for stricture," a hazard of the sailors' dalliances.

The 21st dawned a rare pleasant day, inspiring Usher to go sightseeing at Waterford, fifteen miles away on the French River, which sported "4 publick inns, very reputable," where he "passed the evening merrily." The 25th, he recalled, was "Thanksgiving in Massachusetts," his second away from home. He played cards often, sometimes winning and sometimes losing. As winter deepened, he indulged in "good sleighing." Midshipman Senat and Sailing Master McDonald fought their first of several duels, somehow related to the Perry-Elliott controversy. No one was hurt, but a year later McDonald ultimately succeeded in killing Senat.

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Hand in Hand with Clio

A Sentimental Journey through the Library of the Rhode Island Medical Society

Helen E. DeJong

"The history of medicine is, in fact, the history of humanity itself, with its ups and downs, its brave aspirations after truth and finality, its pathetic failures . . . the very bone and marrow of cultural history." (Fielding H. Garrison: *An Introduction to the History of Medicine*, Philadelphia 1914. The Preface, page 10.)

To me, medical history is living theatre in which individuals, aspiring after truth, have observed, theorized, experimented, disagreed, embraced new ideas and fought bitterly against them, have dared to oppose the Establishment, and, predictably, faced ostracism or even death. In this continuing drama, act follows act, actors appear and disappear but only to the wings, I think, and remain as observers of those who follow.

I stepped into this world of high drama when I was given the job of sorting, culling duplicates, cataloguing, and re-shelving the 30,000 or so volumes in the Library. I was given the key to the huge, glass-fronted bookcase wherein dwelled George Dallas Hersey's special treasures. Grace Dickerman, the Librarian, told me that, in her day, Doctor Hersey didn't allow any books to be taken from the case except with his permission. I assumed I had his permission and went forth to meet the players.

And there they were: William Beaumont and his reluctant guinea-pig, Alexis St. Martin; William Withering listening to an old wives' tale; Edward Jenner and the milkmaids; Ambroise Paré, after a sleepless night, finding that the wounded he had treated with "a digestive made of yolke of an egg, oyle of Roses, and Turpentine" because he lacked the scalding Oyle were resting comfortably and the wounds were not inflamed; and, of course, there were the voices raised in argument over pros and cons of vaccination, anesthesia, blood-letting, asepsis, antisepsis, the germ theory of disease, spontaneous generation, and the origin of life. When the doors of Doctor Hersey's bookcase were opened, it was obvious to me that the case contained much more than just old vellum- and deteriorating calf-bound volumes.

Sixteenth Century

Our oldest volume is Pliny's *Historia Naturalis*, 1501. It has a few worm holes, but the paper is fine and the ink is black. Fine paper and black ink tend to be common in the very early days of printing. We have several other sixteenth century titles, and two of them, Galen's *Opera*, 1525, and Oribasius' *Collectorum Medicinalium*, 1555, were printed by the famous printing-house of the Aldi in Venice. The equally famous house of the Giunti printed our copies of Avicenna's *Liber Canonis*, 1555, and Fracastorius' *Opera Omnia*, 1574.

A translation of *Regimen Sanitatis Salerni*, London, 1557, by Thomas Paynell is the only English imprint. Basle was a major center of printing and several of our oldest volumes came from there: Celsus' *De Arte Medica*, 1552, Plater's *De Corporis Humani Structura*, 1583, Theodosius' *Medicinae Epistolae*, 1553, and Lycosthenes' *Progidiorum ac Ostentorum Chronicon*, 1557. The last named could serve as a resource volume for the modern writer of novels dealing with strange matings and stranger offspring, monsters caused by demons and devils, and "things that appear outside the course of Nature" (Paré). Paré used illustrations from Lycosthenes in his *"On Monsters and Marvels."* The illustrations are superb.

Helen E. DeJong is Librarian Emeritus and an Honorary Member of the Rhode Island Medical Society, Providence, Rhode Island.

Fallopius' *Opera*, 1584, was published in Frankfurt as were Fernelius' *Febrium Curandarum Methodus Generalis*, 1577, Paré's *Opera Chirurgica*, 1594, and the encyclopedic *Medicae Artis Principes post Hippocratem et Galenum*, Excudebat H. Stephanus, 1567.

We complete our listing of the sixteenth century titles by adding: Fernelius' *De Naturale Parte Medicinae*, 1547, Galen's *Galeni In Aphorismas Hippocratis Commentarii*, 1556, and John De Gorris' (or Gorraeus') *Definitorium Medicarum*, 1564.

It would seem that, for a Library of modest size, we have a rather fine representation of the early classics.

Seventeenth and Eighteenth Centuries

Vesalius' *De Fabrica Humani Corporis* (our copy, 1642) introduced me to the world of fact and fantasy called "anatomic illustration" where artist and anatomist met, or were the same person.

Jan Stephan van Calcar, student of Titian, is given credit for the illustrations but it is possible that others in the Titian workshop and even Vesalius may have contributed. The title-page is a busy scene showing Vesalius dissecting, watched by a large and varied audience. The "theatre" shown is probably imaginery, as the present one in Padua wasn't built when Vesalius was the public prosector. The first drawing shows a well-fleshed Adam (with apple) and Eve and, in the foreground, a skull with a serpent emerging. The drawings that follow show a skeleton meditating over a skull, one leaning on a spade, one bowing a head in prayer or despair and muscled figures with beautiful, landscaped backgrounds, and a hanging man with his flesh pulled away. An adult skeleton walks hand in hand with an equally bony child. Were van Calcar's woodcuts moral lessons on man's mortality, or did he chuckle now and then?

Frederik Ruysch's etchings in *Thesaurus Anatomicus Primus-Nonus*, 1721-26, are, literally, out of this world. This physician-artist-museum creator made his own dream (sometimes nightmarish) world filled with small skeletons who have large skulls (one has a plume sprouting from its cranium) and who are busy with many activities — playing a violin (a piece of decayed wood) with a bare branch, conducting an orchestra, playing with a snake, crying, and all surrounded by objects such as stuffed birds, human organs, calculi (or gigantic eggs), blood-vessels injected with a special fluid, and other objects difficult to identify. Ruysch built a museum in which he displayed his "cabinets" which were as surrealistic as his drawings. According to Garrison, some of these cabinets were purchased by Peter the Great and are still in Leningrad in the Anatomical Museum of the Imperial Academy of Sciences. The Soviets, although somewhat careless of human rights, are very careful of their historic memorabilia, and Peter's city, now Leningrad, is a show place. Unfortunately, the Imperial Academy of Sciences wasn't included in our tour when I visited Russia, so I can't vouch for Garrison!

The University was closed when we arrived in Padua, as the students were on strike, but a custodian, glad for company, was happy to give my husband, the friend with whom we were traveling, and me a grand tour of the medical school. It included the anatomic theatre designed and financed by Fabricius ab Aquapendente and there we stood in one of the narrow (18-inch-deep) galleries where William Harvey might have watched Casserius and Fabricius demonstrate during his five years at the University of Padua. From these galleries, students watched Morgagni, who held the chair in anatomy for fifty-six years. The theatre is small, but it speaks of large happenings.

We don't own an early copy of Harvey's *De Motu Cordis*, but we do have his *Opera Omnia*, London, 1766 and *Exercitationes de Generatione Animalium*, Amsterdam, 1651. Giovanni Battista Morgagni, founder of pathologic anatomy, is represented by *Adversaria Anatomica Omnia*, 1762, and *De Sedibus et Causis Morborum*, 1761, published in his 79th year. Those who wish to read Morgagni in English may consult Benjamin Alexander's three-volume translation, *The Seats and Causes of Diseases*, 1769.

Govert Bidloo taught anatomy and was noted for the illustrations in his *Opera Omnia Anatomico-Chirurgica*, of which we have a 1715 edition. His publisher gave 300 impressions of the plates to William Cowper, who published them as his own in the *Anatomy of the Humane Bodies*, Oxford, 1698, a copy of which is in our Library. Bidloo's reaction to the plagiarism appears in his *Opera:* "Gulielmus Cowper Criminis Literatii Citatus."

Other interesting titles showing man's bit by bit discovery of his body are: Thomas Willis' *Cerebri Anatome*, 1664, illustrated by Sir Christopher Wren, who had many interests besides designing buildings; Antonio Scarpa's *Tabulae Neurologicae*, 1794, in which the nerves of the heart are described; Johann Remmelin's *Catoptrum Microcosmicum*, 1619, the first atlas to have superimposed plates; Albinus' *Historia Musculorum Hominis*, 1734, with its beautiful and imaginative plates;

Eustachius' *Tabulae Anatomicae*, 1728, containing the first copper places (plates that had been in the Papal Library for 162 years unprinted) published and annotated by Giovanni Lancisi; the Boerhaave edition of Vesalius' *Opera Omnia Anatomica et Chirurgica*, 2 volumes, 1725, and, moving into the 19th century, we have Charles Bell, who held the chair of surgery at Edinburgh and who taught anatomy to both students and artists. We have his: *A Series of Engravings, Explaining the Course of the Nerves*, 1803; *The Hand. The Bridgewater Treatise, 1833*, and *Essays on the Anatomy of Expression in Painting*, 1806, which is in the Davenport Collection. There are, of course, many other anatomists whose books honor our shelves and who are worthy of mention, but I'll add just one more citation — *Anatomy, Descriptive and Surgical*, London, 1858, by Henry Gray, a most familiar text.

Other titles that show up frequently in dealers' catalogues, Bookmans Price Index, and auction listings and are present in our Library are: Thomas Addison's *On the Constitutional and Local Effects of Disease of the Suprarenal Capsules*, 1855; William Withering's *An Account of the Fox-glove*, 1785, with its still-bright painting of the plant; John Hunter's *On the Blood, Inflammation, and Gunshot Wounds*, 1794; Albrecht von Haller's *Elementa Physiologiae Corporis Humani*, 8 volumes, 1757-66; Richard Lower's *Tractatus de Corde*, 1669; Hermann Boerhaave's *Libellus de Materie Medica et Remediorum Formulis*, 1719; his *Methodus Studii Medici, Emaculata et Accessionibus Locupletata ab Alberto ab Haller*, 1751; and Joannis Swammerdam's *Biblia Naturae; sive Historia Insectorum (Bybel Natuure)* Leyden, 1737, printed in two columns, 1 Latin, 1 Dutch. The superb drawings were purchased by Boerhaave, who wrote a preface for the book and looked after its publication.

Gifts of Former Members

Many of our most valuable books were given by former Fellows of the Society. On February 28, 1903, the Library Committee reported a "donation of more than 1000 volumes by Dr. G. L. Collins 'some quite rare' . . . gathered and used by his distinguished father" (George L. Collins, Sr.). Included in this gift were Edward Jenner's *An Inquiry Into the Causes and Effects of the Variole Vaccine*, 1st edition, London, 1798, 2d edition, 1800, 3d edition, 1801, his *A Letter to Charles Henry Parry, M.D.*, 1822, and *On the Varieties and Modifications of the Vaccine Pustule*, Cheltenham 1806.

Doctor H. G. Partridge, a delightful gentleman and dedicated bookman, served thirty-five terms on the Library Committee, fourteen of them as Chairman. He was available even when out of office to sort gifts, weed duplicates, and give good advice to a novice. Working happily, and dustily, we talked of books, and former members, and history, and of many non-medical subjects such as travel, museums, and cats. Doctor Partridge brought his most treasured medical books to the Library before he died, so that they would have a safe haven. Among the titles: Oliver Wendell Holmes' *Puerperal Fever as a Private Pestilence*, 1855. This was the reprint from Dr. Holmes' article, with introductory remarks by him concerning the controversy, published in answer to many requests. Another was Walter Channing's *A Treatise on Etherization in Childbirth*, 1848, presented "To Josiah Bartlett, M.D., with the author's best regards, Boston May 23, 1849." A copy of Fielding Ould's *A Treatise on Midwifery*, 1748, contains a note that this is very rare.

An account of Madelaine Ray Brown's life and contribution to medicine can be found in the *Rhode Island Medical Journal* 51:751-2, 757, December 1968. The prize editions from her bequest can be found on our shelves. Morgagni, Fracastorius, Ruysch, Paré, Charcot, Descartes, Hales, della Porta, Osler, Boerhaave, Auenbrugger, and many others are represented. Auenbrugger's *Inventum Novum ex Percussione Thoracis Humani* was poorly received and his method of immediate percussion little used until his book was translated by Jean-Nicolas Corvisart: Auenbrugger, Leopold — *Nouvelle Methode pour Reconnaitre les Maladies de la Poitrine par la Percussion de cette Cavité*, Paris, 1808. Auenbrugger seems to have had other interests as he took time to write a libretto for an opera for Maria Theresa, *Der Rauchfangkehrer*. The music was composed by Salieri, whose name has become very familiar thanks to *Amadeus!*

A fine copy of Laënnec's *De l'Auscultation Médiate ou Traité du Diagnostic des Maladies des Poumons et du Coeur . . .*, 1819, 2 volumes, was given to us by Mrs. Helen Batchelder, widow of Doctor Philip Batchelder. Doctor Batchelder rescued the Laënnec from a discard barrel at Rhode Island Hospital, along with some other early titles, and had all of the books restored. They have come home at last to their true abode, having initially been the property of our Library!

Doctor Horace G. Miller, for many years a member of the Library Committee, gave to the Society in 1905 his large collection of books on eye and ear and many files of special journals. Thanks to Doctor Miller, our ophthalmology and

otolaryngology periodical runs start with volume one. The textbook portion of his gift included many published prior to 1850.

Davenport Collection

A perpetual gift came from James Henry Davenport when he gave us his non-clinical library and then left us a fund, the income of which was to be used "for the purchase of books on medical history, medical biography, and extra-curricular writings of physicians." Books purchased from the fund, except for reference volumes, may be borrowed; those in the original collection may be used in the Library.

The only way to appreciate this remarkable collection is to browse, as many visitors have done, and stop whenever a book interests you. It might be fiction, history, biography, poetry, travel, drama, essays, reminiscences, wars, revolutions (American and French), crime, bundling, dueling, or Sandwich glass. There have been few subjects neglected by physician-authors. Two editions from our large number of books by Arthur Conan Doyle have been much admired: *The Adventures of Sherlock Holmes*, London, 1892, and the *Memoirs of Sherlock Holmes*, London, 1894. There are several eighteenth century imprints of value, many notes and letters inserted by Doctor Davenport giving the history of the acquisition of a particular book, and dedications and autographs. The collection has grown as new titles are added yearly through gift and purchase. We try to add books of lasting value.

Caleb Fiske gave the Society seventy-two volumes in 1824 hoping that these would "serve as a nucleus for the Accretion of useful matter." His example was followed by other early members and some of the volumes have survived a pillar-to-post existence and trash barrels. Gifts and bequests after Doctor Hersey became Librarian found a safe haven.

American Contributions

Published material in this country, prior to the American Revolution, consisted of tracts and pamphlets and of reprints of texts used abroad. Some colonial medical students were fortunate in being able to study in Edinburgh, London, Leyden, and Paris and brought back with them the teachings and writings of leading physicians. Our earliest reprint is Nicholas Culpeper's *Pharmacopoeia Londinensis;* or *the London Dispensatory*, Boston, 1720, intended for use in home medicine. Gerard van Swieten's *The Diseases Incident to Armies,* published for the use of military and naval surgeons of America, Philadelphia, 1777, appeared in the midst of battle. Reprints continued to appear after the Revolution, and we have many American imprints of William Cullen, Matthew Baillie, William Heberden, Thomas Sydenham (Benjamin Rush adapted the Philadelphia, 1809, edition of *The Works . . . on Acute and Chronic Diseases* "to the climate and diseases of the United States"), William Smellie, Xavier Bichat, William Hey, Charles and John Bell, Pierre-Ch.-A.-Louis (who taught Oliver Wendell Holmes and the Jacksons of Boston), John and William Hunter, and many others of note.

One of the most important American tracts in our collection is John Morgan's *Discourse upon the Institution of Medical Schools in America,* Philadelphia, 1765. Morgan was a graduate of Edinburgh who traveled on the continent, visiting various medical centers and schools, returning to Philadelphia to found, with William Shippen, the Medical Department of the University of Pennsylvania in 1765. He believed that the teaching of medicine should be based on a broad liberal education and that the physician should belong to "the community of educated men."

Another interesting pre-Revolution tract is Benjamin Colman's *Some Observations on Receiving the Small Pox by Ingrafting or Inoculating*, Boston, 1721. Inoculation became a common practice during the Revolution. Two of our treasures on the subject were published after the war: Benjamin Waterhouse's *A Prospect of Exterminating the Small-pox.* Two parts. Cambridge, 1800, 1802, and his *Information Respecting the Origin, Progress, and Efficacy of the Kine Pock Inoculation*, Cambridge, 1810. The history of vaccination in Providence may be found in Edwin Snow's *Smallpox and the Protective Power of Vaccination*, 1869, and Charles V. Chapin's *The Original Jennerian Vaccine as Preserved and Used in the Public Vaccinations in the City of Providence, 1886.* For anti-vaccinationists we offer a set of pamphlets published by the London Society for the Abolition of Compulsory Vaccination.

American physicians, many of whom had been actively engaged in founding a nation, took up the pen as they returned to medical practice. One of the most prolific writers was Benjamin Rush, called the American Hippocrates and Sydenham by some and in less complimentary fashion by others. He wrote on many subjects both medical and humanistic: *Thoughts Upon Female Education,* 1787; *Animal Life*, 1799; *Essays, Literary, Moral and Philosophical,* 1798; *Medical Inquiries and Observations Upon the Diseases of the Mind,* 1812, and

several editions of his *Medical Inquiries and Observations.* His *An Account of the Bilious Remitting Yellow Fever . . . in Philadelphia,* in the year 1793 is a vivid, first-hand description, for he stayed in the stricken city and treated as many as a hundred patients a day.

James Thacher, America's first medical biographer, was another writer of many interests: *A Military Journal . . . from 1775 to 1783, Boston, 1827; American Medical Biography,* Boston, 1828; *Observations on Hydrophobia, Plymouth, 1812; An Essay on Demonology, Ghosts and Apparitions* (with) an *Account of the Witchcraft Delusion at Salem,* Boston, 1831, and a book on medical practice and one dispensatory.

Many of the early American imprints were concerned with epidemic fevers — spotted, intermittent, recurrent, putrid, nervous, malignant, petechial, and other types difficult for a layman to identify. I found them difficult to catalogue until I picked John Shaw Billings' brain and used the Index-Catalogue of the Surgeon-General's Office. If he said a spotted fever belonged under cerebrospinal meningitis and not typhus, that's where I put it. All joking aside, these texts are important in the history of epidemiology. We have: Noah Webster's *A Brief History of Epidemic and Pestilential Diseases,* Hartford, 1799, 2 volumes; Elisha Bartlett's *The History, Diagnosis, and Treatment of the Fevers of the United States,* 1847 (William Osler considered this Bartlett's most important contribution to clinical medicine); Elisha North's *A Treatise on a Malignant Epidemic, Commonly Called Spotted Fever,* 1811; Thomas Miner's *Typhus syncopalis . . . the spotted Fever of New England Epidemic of 1823,* 1825; discussions about yellow fever by Matthew Carey, William Currie, Nathaniel Potter, and Nathan Smith's *A Practical Essay on Typhous Fever,* 1824. Nathan Smith was a professor in Dartmouth College and built up the medical school, helped in developing those at Yale, Bowdoin, and the University of Vermont, wrote and taught. One of our interesting manuscripts consists of the notes taken by medical student Daniel Lyman from Smith's lectures during 1809.

This year marks the centennial of the birth of Daniel Drake, whose *A Systematic Treatise, Historical, Etiological, and Practical on the Principal Diseases of the Interior Valley of North America,* 1850-54, has been called "a classic of medical geography." Fielding Garrison calls him "The greatest physician of the West, and one of the most picturesque figures in American medicine." We have this and other writings. We have both the literary and clinical works of Silas Weir Mitchell.

Representing New England and our own Rhode Island are many valuable, interesting publications both clinical and literary. Usher Parsons we have in both hard cover and unbound pamphlets, including his prize-winning Fiske Fund and Boylston Prize Essays, his account of the Battle of Lake Erie, the manual on the art of making anatomical preparations, studies of the Indians, accounts of former Fellows, history of physicians in Rhode Island before the Society was founded, and many, many other subjects, for his interests were varied. Charles Parsons, his son, is also well represented.

Oliver Wendell Holmes appears, wearing all his hats — poet, novelist, essayist, clinician, and witty commentator. We have Isaac Ray's famous *Medical Jurisprudence of Insanity,* 1838, and other writings by and about him. Charles V. Chapin became a member of the Rhode Island Medical Society on June 9, 1880, the same day he won the Fiske Fund Prize for his essay on *The Sympathetic Nerve — its Relation to Disease.* He published many articles, reports, and several books, all of which may be found in the Library. His scrapbooks and manuscripts are housed at the Rhode Island Historical Society.

We have a large collection of unbound material of historical interest. Included in this section are annual discourses by appointed orators Edmund T. Waring, 1812 (ms.), Henry E. Turner, 1813, Joseph Comstock, 1814, and Sylvanus Clapp, 1854; Benjamin Waterhouse's academic dissertation submitted for his medical degree at Edinburgh, and a copy of his public health lecture *Cautions to Young Persons Concerning Health . . . Shewing the Evil Tendency of the Use of Tobacco . . .* 1805; Elisha Bartlett's *A Discourse on the Times, Character and Writings of Hippocrates,* 1852, and the *Report of the Case John Dorrance against Arthur Fenner* (and) *the Case Arthur Fenner vs. John Dorrance,* involving Resurrectionism, Doctor Pardon Bowen, and a beaver hat, Providence, 1802.

Medical information traveled from Europe to America for many years, but two dramatic events in the first half of the nineteenth century sent news abroad. Our copy of the *Medical Recorder* 8:14-19, January 1825 reported an interesting case of an abdominal wound by "Joseph Lovell, an army surgeon." Later, 8:840, 1825, the editors corrected it — "should have been mentioned as reported by Dr. William Beaumont." Thus started the saga of Beaumont and Alexis St. Martin, published in the *Medical Recorder* until "the man ab-

sconded to Canada in Angnst 1825," and began again in 1829, continuing until March 1831. Beaumont's book: *Experiments and Observations on the Gastric Juice and the Physiology of Digestion* was published in Plattsburgh, New York in 1833; reprinted in Boston, 1834, and a second edition, Burlington 1847. We have an edition published in Edinburgh in 1838, which the late Henry Schuman, authority and dealer in rare medical books, said was extremely rare. It was edited by Andrew Combe with notes recognizing the importance of the work stating that "From Dr. Beaumont's work also being still inaccessible to the British reader, it is a bare act of justice to him . . . to make its contents known as widely as possible."

Discovery of Ether Anaesthesia

Ether or nitrous oxide "frolics" were considered great fun on both sides of the Atlantic, and the possibility that inhalation anaesthesia could be used in surgery had been considered, but medical historians seem to agree that surgical anesthesia was the gift of the United States. The announcement of the gift was published in the *Boston Medical & Surgical Journal* volume 35, November 18, 1846 in Henry Jacob Bigelow's article describing William T. G. Morton's successful demonstration of the use of ether in surgery. We have the Journal and copies of many of the publications that followed in the bitter Ether Controversy between former friends and associates Horace Wells, Charles T. Jackson, and Thomas T. G. Morton, each of whom claimed to be the *first*. A long and passionate claim to being *first* appears in Crawford W. Long's obituary in the *Transactions of the Medical Association of Georgia* 32:263-87, 1881. However, it wasn't until 1853 that Doctor Long reported the surgery he performed in 1842 and had it attested by the patient, James Venable. J. Marion Sims defended Long's claim in his article, "The discovery of Anaesthesia" in the *Virginia Medical Monthly*, but his his last paragraph has the best solution: "I propose, then, that the whole medical profession, North, South, East and West write in asking Congress . . . to appropriate an anaesthesia fund, to be divided equally between the families of Long, Wells, Morton and Jackson. . . . How small this pittance when measured by the benefits these men conferred upon the world!" On the literary side, there is Silas Weir Mitchell's poem *The Birth and Death of Pain*, read on the 50th anniversary of Morton's demonstration, 1896, and Nathan Rice's *Trials of a public benefactor*, 1859.

Periodical Holdings

Our periodical holdings provide a vast reservoir of medical history. The Society ordered subscriptions for its two librarians in 1825, early physicians gave their copies, and the Providence Medical Association started its collection in 1850. These volumes were recovered by Doctor Hersey when he started his campaign in 1879 to rebuild the library. We have the first native American journal, *Medical Repository* (1797-1824); the *Philadelphia Journal of the Medical and Physical Sciences*, founded in 1820 and renamed the *American Journal of the Medical Sciences* when the new series started in 1827; the *New England Journal of Medicine and Surgery* (1812-1828), and the predecessor of the present *New England Journal of Medicine*, the *Boston Medical and Surgical Journal* which began in 1828. These are but a few of the titles, and these are the periodicals in which articles by our Rhode Island physicians often appeared. The *Boston Med Surg J* printed not only articles, but news items, minutes of meetings, obituaries, and even weather of Rhode Island. Aaron C. Wylley's annual discourse, August 25, 1819 was published in the *Medical Repository*.

Would you be interested in reading James Paget's original article, "On a Form of Chronic Inflammation of Bones (Osteitis Deformans)"? See the *Medico Chirurgical Transactions* (London) 60:37-63, 1877. You will find "Three Cases of Extirpation of Diseased Ovaria" by Ephraim McDowell in the *Eclectic Repertory and Analytic Review* 7:242-4, 1817. Before Oliver Wendell Holmes had "Puerperal Fever as a Private Pestilence" printed in pamphlet form, it appeared in the *New England Quarterly Journal of Medicine and Surgery* 1:503-30, April 1843. An important contribution of J. Marion Sims is his article "On the Treatment of Vesico-vaginal Fistula" in the *American Journal of the Medical Sciences* n.s. 23:59-82, 1852. The potato famine in Ireland? Try the *Dublin Journal of Medicine*. Medicine in the Confederacy? The *Confederate States Medical Journal* will be helpful.

Our long runs of the *Transactions* of the various states and of the American Medical Association contain many articles of importance as well as the minutes of the organizations concerned. Again, we must thank Doctor Hersey for building up the exchanges with other states of *Transactions* and of state medical journals.

Access to the material printed in serial publications is made possible by our collection of reference tools: the *Index-Catalogue of the Surgeon-General's Office* and the first *Index Medicus*, both founded by the army-surgeon-turned-expert-

bibliographer John Shaw Billings, and of all the descendants of the first indexes. Various textbooks listing medical classics are also available, and the National Library of Medicine is working toward complete coverage of historical citations through computers.

Quackery and How-To Books

Man's insatiable desire for the Perfect Cure and his willingness to swallow magic potions are important enough in his history to warrant having books on Homeopathy (the Rhode Island Medical Society and Hahnemann were both born in 1812), Thomsonianism, Brunonianism, Hydropathy, Naturopathy, and many others. We have Thomas Prior's *An Authentic Narrative of the Success of Tar Water, . . .* Providence, 1793, and several of Bishop George Berkeley's writings favorable to tar water. Not only do we have a pair of Perkin's tractors on display in the Library but we have many pamphlets advocating their use and one title that gives a negative view: *Terrible Tractoration! A Poetical Petition Against Galvanising Trumpery . . .*, 1804, by Christopher Caustic (Thomas Green Fessenden.) Member Dan King's three-hundred-and-thirty-four page book, *Quackery Unmasked*, 1858, is an interesting contribution.

We have a small group of "receipt" books, now collectors' items, but once essential for families living in areas where physicians were lacking. These volumes cover medical treatment for man and beast and are "how-tos" for about anything you needed to know. Books on family medicine were important, too, and we have editions of Simon-André Tissot's *Advice to the People*, William Buchan's *Domestic Medicine*, George Cannon's *Botanical Family Medicine . . . free from Mineral and Mercurial Preparations* (would be popular today!), and George Capron's *Popular Medicine*. Doctor Capron was a member of our Society and his book ran to several editions.

I have used Jacob Bigelow's *American Medical Botany* and other texts by physician-botanists for displays on several occasions. Research on ancient remedies has numerous times sent us hunting in our excellent collection of pharmacopoeias. Our hospital and public health reports are often used. Of major importance are our directories of physicians, for these provide sources for biographers, genealogists, and students writing theses on physician distribution and other topics in medical sociology.

Perhaps the most fascinating historical sources in our Library, and the most important to us, are the records of the Rhode Island Medical Society and the Providence Medical Association. I've searched the minutes so many times that I feel I've attended every meeting beginning with April 22, 1812. Fellows have become real people, not just names and I've been a participant in their discussions. To supplement the minutes, we have letters, personal papers, programs, menus (times have changed!), and obituaries, which were often major literary efforts in our early years. We also have portraits, photographs, cups, and instruments. The oldest of the latter are on permanent display in the Grace E. Dickerman Reading Room, but there are many more packed away.

In my walk through time, I have neglected the twentieth century (which is almost all history now) and the late nineteenth. We *do* have many books on our shelves that are, or are about to be, "classics" and many works by such giants as William Osler, but the field is too vast for present consideration!

I have, as have others before me, picked my favorites, and some specialties were not represented by rare items, so that this account is in no way complete. It could be many pages longer and still not exhaust the treasures.

I've enjoyed the opportunity to take a CE course in my favorite subject, the history of medicine.

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1A. Title of Publication: *Rhode Island Medical Journal*
1B. Publication No.: 03637913

2. Date of Filing: September 30, 1986

3. Frequency of issue/Annual subscription price: Monthly/ $15

4. Location of known office of publication: 106 Francis Street, Providence County, Rhode Island 02903

5. Location of headquarters or general business offices of the publishers: 106 Francis Street, Providence, Rhode Island 02903

6. Names and addresses of publisher, editor, and managing editor:
Publisher: Rhode Island Medical Society, 106 Francis Street, Providence, RI 02903
Editor: Seebert J. Goldowsky, MD, 106 Francis Street, Providence, RI 02903
Managing Editor: Jack A. Perkins, 106 Francis Street, Providence, RI 02903

7. Owner: Rhode Island Medical Society, 106 Francis Street, Providence, RI 02903

8. Known bondholders, mortgages, and other security holder owning 1 per cent or more of total amount of bonds, mortgages or other securities: None

9. For completion by nonprofit organizations authorized to mail at special rates. The purpose, function, and nonprofit status of this organization and exempt status for Federal income tax purposes have not changed during preceding 12 months

10. Extent and nature of circulation

	Average copies of issue during preceding 12 months	*Actual no. of copies published nearest to filing date*
A. Total no. of copies (Net press run)	1,688	1,671
B. Paid circulation		
1. Sales through dealers and carriers, street vendors, and counter sales		
2. Mail subscription	1,543	1,543
C. Total paid circulation	1,543	1,543
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Jack Perkins
Managing Editor

Information for Authors

Manuscripts: Manuscripts will be accepted for consideration with the understanding that they are original contributions, have never been published or submitted elsewhere, and are submitted only to the *Rhode Island Medical Journal.*

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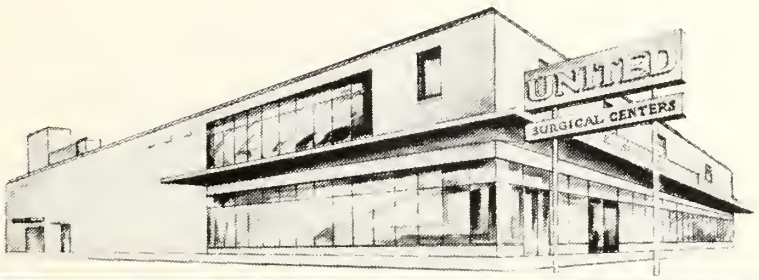
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November 10, 1986	THE USE OF MEDICATION DURING PREGNANCY	Donald R. Coustan, MD Director, Maternal-Fetal Medicine Woman & Infants Hospital
(Sara Rosenbaum, PhD, will speak briefly on the Adverse Drug Reaction Reporting Project)		
December 8, 1986	OPHTHALMOLOGIC PROBLEMS FOR THE NON-OPHTHALMOLOGIST	Deborah Murphy, MD Practicing Ophthalmologist Providence, Rhode Island
January 12, 1987	UPDATE ON RARE DISEASES IN PEDIATRICS: KAWASAKI DISEASE, LYME DISEASE, AND REYES SYNDROME	Penelope J. Dennehy, MD Assistant Physician, Division of Infectious Diseases Rhode Island Hospital
February 9, 1987	OSTEOPOROSIS	Joseph R. Tucci, MD Director, Division of Endocrinology Roger Williams Hospital Roy K. Aaron, MD Chief, Division of Orthopedic Research Rhode Island Hospital
March 9, 1987	**ANNUAL MEETING** **Wannamoisett Country Club** RECREATIONAL ATHLETICS: RISK AND REWARD	Kenneth G. Knowles, MD Senior Orthopedic Consultant and Associate Team Physician Brown University Vincent Yakavonis, MD Practicing Orthopedic Surgeon Providence, Rhode Island
April 13, 1987	MIDDLE CLASS SUBSTANCE ABUSE	John P. Femino, MD Medical Director Good Hope Center
May 11, 1987	SURGICAL TREATMENT FOR COMPLICATION OF ACUTE MYOCARDIAL INFARCTION	Arun K. Singh, MD, FRCS Practicing Surgeon Providence, Rhode Island

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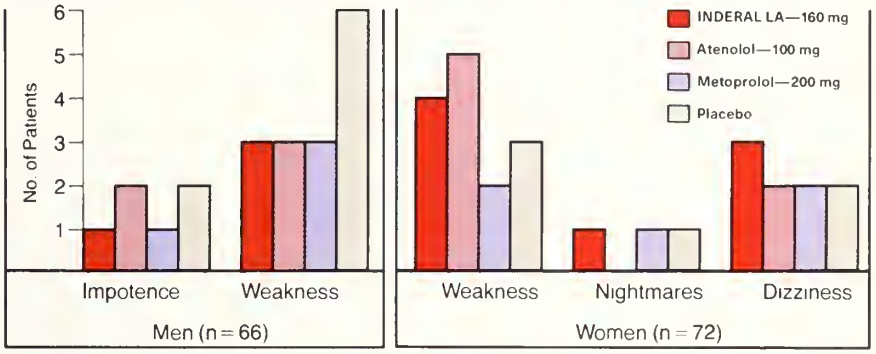
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Hydrochlorothiazide: Hydrochlorothiazide is contraindicated in patients with anuria or hypersensitivity to this or other sulfonamide-derived drugs.

WARNINGS

Propranolol hydrochloride (INDERAL® LA): CARDIAC FAILURE. Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated, and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or propranolol should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction following *abrupt* discontinuance of propranolol therapy. Therefore, when discontinuance of propranolol is planned, the dosage should be gradually reduced and the patient carefully monitored. In addition, when propranolol is prescribed for angina pectoris, the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If propranolol therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute propranolol therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

THYROTOXICOSIS. Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

MAJOR SURGERY. The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

Nonallergic Bronchospasm (eg, chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD, IN GENERAL, NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution, since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

DIABETES AND HYPOGLYCEMIA. Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin. Hypoglycemic attacks may be accompanied by a precipitous elevation of blood pressure.

Hydrochlorothiazide: Thiazides should be used with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. In patients with impaired renal function, cumulative effects of the drug may develop.

Thiazides should also be used with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma.

Thiazides may add to or potentiate the action of other antihypertensive drugs. Potentiation occurs with ganglionic or peripheral adrenergic-blocking drugs.

Sensitivity reactions may occur in patients with a history of allergy or bronchial asthma.

The possibility of exacerbation or activation of systemic lupus erythematosus has been reported.

PRECAUTIONS

Propranolol hydrochloride (INDERAL® LA): GENERAL. Propranolol should be used with caution in patients with impaired hepatic or renal function. Propranolol is not indicated for the treatment of hypertensive emergencies.

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that propranolol may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

CLINICAL LABORATORY TESTS. Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS. Patients receiving catecholamine-depleting drugs, such as reserpine, should be closely observed if propranolol is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity, which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY. Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies, in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

PREGNANCY. Pregnancy Category C. Propranolol has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximal recommended human dose. There are no adequate and well-controlled studies in pregnant women. Propranolol should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

NURSING MOTHERS. Propranolol is excreted in human milk. Caution should be exercised when propranolol is administered to a nursing mother.

PEDIATRIC USE. Safety and effectiveness in children have not been established.

Hydrochlorothiazide: GENERAL. Periodic determination of serum electrolytes to detect possible electrolyte imbalance should be performed at appropriate intervals.

All patients receiving thiazide therapy should be observed for clinical signs of fluid or electrolyte imbalance, namely: hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when the patient is vomiting excessively or receiving parenteral fluids. Medication such as digitalis may also influence serum electrolytes. Warning signs irrespective of cause are: Dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea and vomiting.

Hypokalemia may develop, especially with brisk diuresis, when severe cirrhosis is present, or during concomitant use of corticosteroids or ACTH.

Interference with adequate oral electrolyte intake will also contribute to hypokalemia. Hypokalemia can sensitize or exaggerate the response of the heart to the toxic effect of digitalis (eg, increased ventricular irritability). Hypokalemia may be avoided or treated by use of potassium supplements, such as foods with a high potassium content.

Any chloride deficit is generally mild and usually does not require specific treatment, except under extraordinary circumstances (as in liver or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction, rather than administration of salt, except in rare instances when the hyponatremia is life-threatening. In actual salt depletion, appropriate replacement is the therapy of choice.

Hyperuricemia may occur or frank gout may be precipitated in certain patients receiving thiazide therapy.

Insulin requirements in diabetic patients may be increased, decreased, or unchanged. Diabetes mellitus which has been latent may become manifest during thiazide administration.

If progressive renal impairment becomes evident, consider withholding or discontinuing diuretic therapy.

Thiazides may decrease serum PBI levels without signs of thyroid disturbance.

Calcium excretion is decreased by thiazides. Pathologic changes in the parathyroid gland with hypercalcemia and hypophosphatemia have been observed in a few patients on prolonged thiazide therapy. The common complications of hyperparathyroidism, such as renal lithiasis, bone resorption, and peptic ulceration, have not been seen. Thiazides should be discontinued before carrying out tests for parathyroid function.

DRUG INTERACTIONS. Thiazide drugs may increase the responsiveness to tubocurarine.

The antihypertensive effects of thiazides may be enhanced in the postsympathectomy patient. Thiazides may decrease arterial responsiveness to norepinephrine. This diminution is not sufficient to preclude effectiveness of the pressor agent for therapeutic use.

PREGNANCY. Pregnancy Category C. Thiazides cross the placental barrier and appear in cord blood. The use of thiazides in pregnancy requires that the anticipated benefit be weighed against possible hazards to the fetus. These hazards include fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult.

NURSING MOTHERS. Thiazides appear in human milk. If use of the drug is deemed essential, the patient should stop nursing.

PEDIATRIC USE. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Propranolol hydrochloride (INDERAL® LA): Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular. Bradycardia, congestive heart failure, intensification of AV block, hypotension, paresthesia of hands, thrombocytopenic purpura, arterial insufficiency, usually of the Raynaud type.

Central Nervous System. Lightheadedness, mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to catatonia, visual disturbances, hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal. Nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic. Pharyngitis and agranulocytosis, erythematous rash; fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory. Bronchospasm.

Hematologic. Agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune. In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous. Alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes, and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

Hydrochlorothiazide:

Gastrointestinal. Anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation, jaundice (intrahepatic cholestatic jaundice), pancreatitis, sialadenitis.

Central Nervous System. Dizziness, vertigo, paresthesias, headache, xanthopsia.

Hematologic. Leukopenia, agranulocytosis, thrombocytopenia, aplastic anemia.

Cardiovascular. Orthostatic hypotension (may be aggravated by alcohol, barbiturates, or narcotics).

Hypersensitivity. Purpura, photosensitivity, rash, urticaria, necrotizing angiitis (vasculitis, cutaneous vasculitis), fever, respiratory distress, including pneumonitis, anaphylactic reactions.

Other. Hyperglycemia, glycosuria, hyperuricemia, muscle spasm; weakness, restlessness, transient blurred vision.

Whenever adverse reactions are moderate or severe, thiazide dosage should be reduced or therapy withdrawn.

* The appearance of these capsules is a registered trademark of Ayerst Laboratories

REFERENCE:

1. Ravid M, Lang R, Jutrin I. The relative antihypertensive potency of propranolol, oxprenolol, atenolol, and metoprolol given once daily. *Arch Intern Med* 1985;145:1321–1323.

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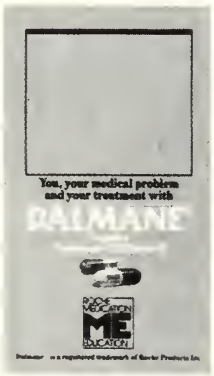
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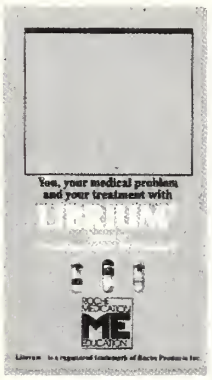
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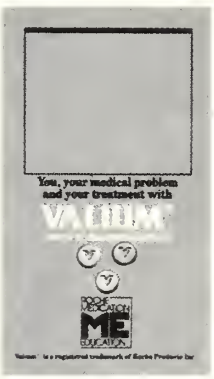
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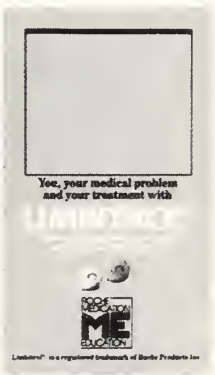
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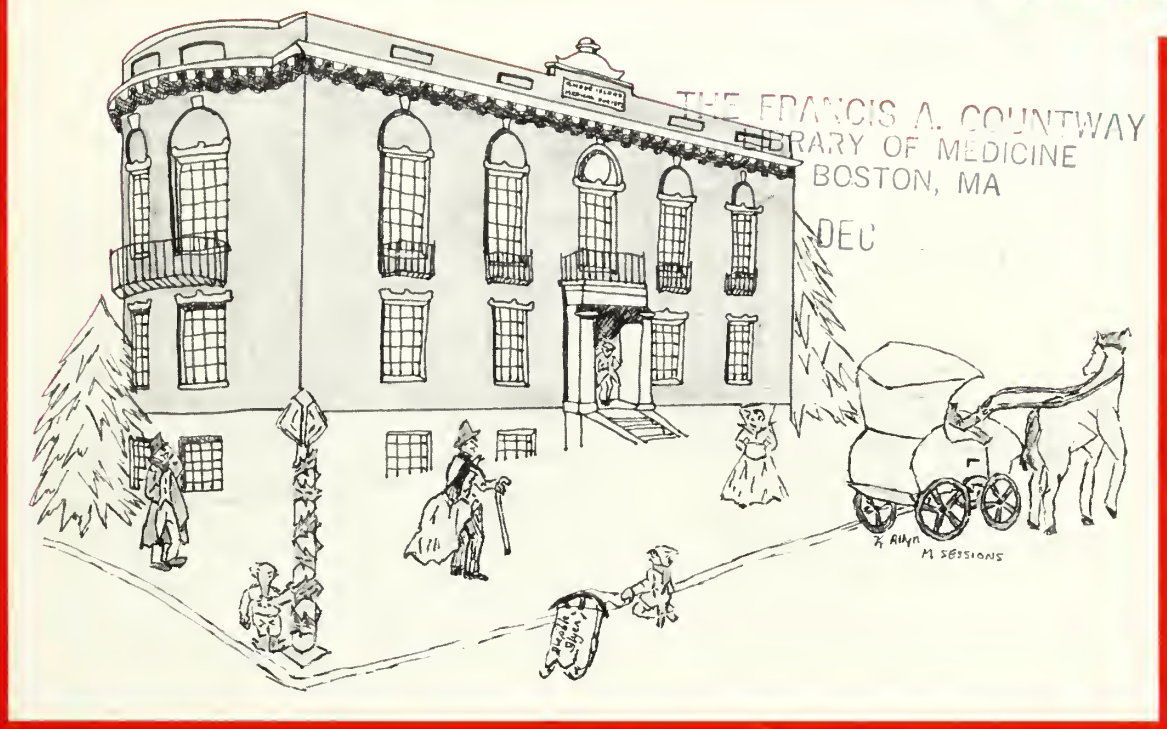
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Rhode Island Medical Journal

December 1986
Volume 69, Number 12



THE FRANCIS A. COUNTWAY
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Contraindications: Concomitant use with other potassium-sparing agents such as spironolactone or amiloride. Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: **Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired.** If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

Precautions: The bioavailability of the hydrochlorothiazide component of 'Dyazide' is about 50% of the bioavailability of the single entity. Theoretically, a patient transferred from the single entities of triamterene and hydrochlorothiazide may show an increase in blood pressure or fluid retention. Similarly, it is also possible that the lesser hydrochlorothiazide bioavailability could lead to increased serum potassium levels. However, extensive clinical experience with 'Dyazide' suggests that these conditions have not been commonly observed in clinical practice. Angiotensin-converting enzyme (ACE) inhibitors can elevate serum potassium; use with caution with 'Dyazide'. Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids, and during concurrent use with amphotericin B or corticosteroids or corticotropin [ACTH]). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Cumulative effects of the drug may develop in patients with impaired renal function. Thiazides should be used with caution in patients with impaired hepatic function. They can precipitate coma in patients with severe liver disease. Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic and hemolytic anemia have been reported with thiazides. Thiazides may cause manifestation of latent diabetes mellitus. The effects of oral anticoagulants may be decreased when used concurrently with hydrochlorothiazide; dosage adjustments may be necessary. Clinically insignificant reductions in arterial responsiveness to norepinephrine have been reported. Thiazides have also been shown to increase the paralyzing effect of nondepolarizing muscle relaxants such as tubocurarine. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. Triamterene has been found in renal stones in association with the other usual calculus components. Therefore, 'Dyazide' should be used with caution in patients with histories of stone formation. A few occurrences of acute renal failure have been reported in patients on 'Dyazide' when treated with indomethacin. Therefore, caution is advised in administering nonsteroidal anti-inflammatory agents with 'Dyazide'. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia is uncommon with 'Dyazide', but should it develop, corrective measures should be taken such as potassium supplementation or increased dietary intake of potassium-rich foods. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Concurrent use with chlorpropamide may increase the risk of severe hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function. Thiazides may add to or potentiate the action of other antihypertensive drugs. Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances; postural hypotension (may be aggravated by alcohol, barbiturates, or narcotics). Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and respiratory distress including pneumonitis and pulmonary edema, transient blurred vision, sialadenitis, and vertigo have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components. Rare incidents of acute interstitial nephritis have been reported. Impotence has been reported in a few patients on 'Dyazide', although a causal relationship has not been established.

Supplied: 'Dyazide' is supplied as a red and white capsule, in bottles of 1000 capsules; Single Unit Packages (unit-dose) of 100 (intended for institutional use only); in Patient-Pak™ unit-of-use bottles of 100.

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Newsletter

RHODE ISLAND MEDICAL SOCIETY
December 1986

Peter D.T. Clarisse, MD, President
Jack A. Perkins, Editor

RHODE ISLAND MEDICAL SOCIETY WINS LAWSUIT TO BLOCK SURCHARGE ON MALPRACTICE INSURANCE

On November 10 the Rhode Island Medical Society (RIMS) received a favorable decision from the Superior Court in its effort to block a surcharge of 16 2/3 per cent on premiums paid for malpractice insurance. The Department of Business Regulations (DBR) had proposed the increase for all physicians renewing their policies with the Joint Underwriting Association (JUA). The Superior Court ruled that the DBR had no authority to impose an additional surcharge on existing policyholders. Most doctors in the state are insured by the JUA. To become a policyholder each insured pays an initial surcharge of 33 1/3 per cent.

"We contended that the DBR did not have the authority to grant an additional surcharge and are pleased with the Superior Court's decision," said Peter D.T. Clarisse, MD, president of the Medical Society. "The fact that the DBR recognizes that the liability insurance problem still exists is encouraging. However, its solution is like treating a symptom while ignoring the cause," continued Clarisse.

The success of the lawsuit has resulted in the following savings for those doctors insured by the JUA:

CLASS	1986-1987 SAVINGS*
I	$784
II	$1411
III	$2353
IV	$3137
V	$3921

* for $1 million, $3 million coverage

The medical malpractice insurance crisis first received attention in 1975 when the JUA was authorized by the General Assembly. The availability of liability insurance was shrinking, and many physicians were left without a carrier.

The JUA was established to create a system "to pool expenses and losses in providing such insurance." Competition to provide medical liability insurance is still limited, and the JUA regularly applies for increases in physicians' premiums.

The Medical Society testified in November before the blue ribbon commission created by Governor Edward DiPrete to examine the current liability crisis for all businesses, municipalities, and professions in Rhode Island. RIMS renewed its call for an overhaul of the current tort system which settles liability disputes. "The system is not working. There is no rhyme or reason to our present system which allows juries, regardless of establishing negligence, arbitrarily, to determine awards that may be in litigation for years before an injured party is compensated. A program is needed that would allow a patient to be compensated promptly for a bad outcome of a medical procedure."

The Governor's commission is expected to offer legislative recommendations to Governor DiPrete before the General Assembly convenes in January 1987. Dr. Clarisse is a member of this panel. The Governor will review the recommendations and have legislation drafted. He indicated at a breakfast meeting with RIMS in October that he will press for a legislative solution for the far-reaching liability crisis.

DiPRETE SEEKS REGULATORY POWERS OVER INSURANCE/DOCTOR RELATIONSHIP

Rhode Island Medical Society President Peter D.T. Clarisse, MD, has written to Governor Edward DiPrete offering the Society's input in DiPrete's legislative initiative to increase state regulation of health insurance carriers. DiPrete has directed the Departments of Health and Business Regulation to draft legislation concerning the state's "oversight authority over the relationship between health service organizations and physicians."

DiPrete's interest in this matter was prompted by his concern for consumers of health benefits plans and the possible adverse affects of the "prudent buyer policy" of Blue Cross/Blue Shield on the availability of health insurance. In his letter Clarisse indicated that the Society shares the Governor's concerns. Clarisse also offered assistance stating: "Any legislative solution will undoubtedly affect consumers, health insurance carriers, and physicians. Therefore, I am offering the cooperation of the medical profession in addressing this matter."

A further related legislative proposal is also being contemplated. Representative Joseph L. Casinelli, Chairman of the House Corporation Committee, announced that he would introduce a bill increasing the state's authority "if an investigation confirms that legislation of this type is warranted."

APPOINTMENTS MADE TO NEW MEDICAL BOARD

Governor Edward DiPrete has appointed 11 of the 13 members of the newly created Rhode Island Board of Medical Licensure and Discipline. Five Rhode Island Medical Society members were selected to sit on the panel which begins monitoring physicians performance in 1987.

The new 13 member board was established by the 1986 General Assembly to replace the current Board of Medical Review and the Board of Examiners in Medicine. The law mandates the make-up of the board to consist of the state health department director, who serves as chairman; six physicians, two of whom must be osteopaths; a hospital administrator, a lawyer, and four public representatives, one of whom must be over 60.

The RIMS appointments are:

- H. Denman Scott, MD, Director of the Rhode Island Health Department.
- Frances P. Conklin, MD, radiologist from Providence.
- Edmund T. Hackman, MD, general practitioner from Warwick.
- Edwin N. Foreman, MD, Director of Pediatric Residency at Rhode Island Hospital.
- Robert P. Sarni, MD, family practitioner from Cranston.

The other appointments are:

- Edward A. Azevedo, President of St. Joseph Hospital.
- James Cole, DO.
- Jack Fireman, DO.
- Henry D. Sharpe, Jr., Chairman of the Board of Brown and Sharpe Manufacturing Co.
- Sherman Berger, Speaker of the House of the Silver Haired Legislature.
- Harry V. McKenna , retired radio newsman from Cranston.

The other two members are expected to be appointed before January 1, 1987.

SOCIETY UNDERGOING SELF-EXAMINATION

The Rhode Island Medical Society continues to explore how best to meet the changing environment of medical practice. A report developed at a special Council meeting in October addresses individual physicians' needs in light of the Society's capacity successfully to meet these needs.

Also, RIMS's current activities are being reviewed by the Executive Committee and Council to develop recommendations for

consideration at the House of Delegates meeting in January. Two activities which have received considerable attention are the Society's role in providing scientific information and in general its communications mechanisms.

One concern has to do with scientific information, which is one of physicians' highest priorities. In its early history, the Medical Society was the primary source of this information. However, over the years specialty societies, hospitals, and medical schools have become the principle sources of this information. There is concern in some quarters that RIMS devotes too many of its resources to storage and dissemination of scientific information. These resources in this view should be committed to other Society functions such as advocacy, representation, and socio-economic information.

A second concern relates to the Society's communications process. A new newsletter is forthcoming and will appear independent of the Journal. This will give the Society more flexibility in providing important imformation, for example legislative issues, to its members in a timely manner (see CHECK-UP next column).

The report generally gives the Society high marks for having made many necessary adjustments to meet the needs of a changing profession. RIMS President Peter D.T. Clarisse, MD, has challenged the Society to make further adjustments in order to function effectively throughout the twentieth century.

COUNCIL OPPOSES INSURANCE INVOLVEMENT IN CREDENTIALING

The RIMS Council in support of the RIMS Committee on Medical Economics strongly opposes the involvement of insurance carriers in credentialing physicians for services at a hospital. The Committee on Medical Economics concluded that the Blue Cross and Blue Shield (BC/BS) Alternate Provider Number Agreement with hospitals

(Credentialing continued)

could result in excluding a BC/BS non-participating physician from providing a service to the hospital.

The Council has concluded that this practice in effect could be credentialing by an insurance carrier. Credentialing, the Council maintains, should continue to be the responsibility of the hospitals and is not a proper function of an insurance carrier.

CHECK-UP A NEW RIMS PUBLICATION

Starting in January 1987 the Rhode Island Medical Society will publish CHECK-UP, a new newsletter. CHECK-UP will replace the current RIMS NEWSLETTER and will not be a part of the Rhode Island Medical Journal.

The new publication is the result of extensive discussions of the RIMS Council concerning the communications mechanisms of the Society. The timeliness of the current newsletter has often been questioned. By separating it from the Journal the production schedule will be improved.

CHECK-UP will be a monthly publication. When warranted, additional special issues will be published. Featured in the newsletter will be a report from the RIMS president and other matters of interest to members. Look for your CHECK-UP in January 1987.

HHS ANNOUNCES CATASTROPHIC INSURANCE PLAN

Health and Human Services Secretary Otis Bowen, MD, announced an initiative to provide insurance to protect the elderly from the enormous costs of catastrophic illnesses. Secretary Bowen's plan comes with a heavy price tag and opposition is expected from the White House.

The catastrophic illness insurance proposal would cap out-of-pocket costs to (see Catastrophic - next page)

(Catastrophic continued)

the elderly at $2000 per year. Other provisions of the plan include the following:

- The program would be voluntary with initial monthly premiums set at $4.92. The cap and the premiums would increase in accordance with the rate of medical cost inflation.
- Individual Medical Accounts (IMAs) would allow working individuals to make tax-free contributions up to $1000 a year to a special savings account to cover future nursing home costs.
- A full deduction for health insurance costs would be allowed for self-employed individuals.
- Employers offering health insurance would be required to include catastrophic illness coverage.
- A $100 tax credit would be allowed for purchases of long-term care insurance.

PHYSICIANS NEEDED TO AID HOMELESS

The Traveler's Aid Society has received a grant of $50,000 from Gulf and Western Corporation toward support of a mobile medical clinic to aid the homeless population of Providence. There are nearly 1000 homeless individuals, including 150 children, on the streets of Providence with no access to the medical care system.

Physicians are needed to donate three or four hours of their time every three months to assist Traveler's Aid in this endeavor. Orientation and training will be provided, and physicians in all specialties are sought.

"It's grass-roots medicine and a good re-education for physicians," said Herbert Rakatansky, MD, RIMS past president and organizer of the Society's recruitment drive.

Volunteers should call Dr. Rakatansky at the Rhode Island Medical Society, 331-3207.

REAGAN SIGNS VACCINE COMPENSATION LAW

Amid expressions of considerable difference of opinion by members of his cabinet, President Reagan signed the omnibus health bill passed by Congress on October 18. The new law includes a drug export expansion program, the termination of federal funding for state health-planning initiatives, protection for doctors involved in peer review activities, and a highly controversial vaccine injury compensation system.

The Reagan cabinet was divided on the vaccine injury compensation provision. Attorney General Edwin Meese, III, opposed the program, claiming it was not the solution to the liability crisis and would result in a new federal entitlement system. Otis Bowen, MD, Secretary of Health and Human Services, strongly supported the program.

The new law establishes a national vaccine-injury compensation program designed to bypass the courts. Claimants dissatisfied with judgements handed down under the new federal system could still have access to the courts, but would then forfeit their right to return to the new federal system. Although now law, the program can not become operational until Congress passes a funding mechanism.

CAP ON MALPRACTICE AWARDS RULED UNCONSTITUTIONAL

A federal judge ruled unconstitutional a law limiting medical malpractice awards. On November 5, US District Court Judge James Michael, Jr, ruled that the $1 million cap for malpractice awards under Virginia state statutes violates the Seventh Amendment guarantee of the right to jury trial.

This federal decision could have national ramifications. However, medical malpractice limits in California and Indiana have been upheld by state and federal courts, including the US Supreme Court.

Rhode Island Medical Journal

December 1986
Volume 69, Number 12

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Drawing by RIMS staff members Kimberly Allyn and Marcia Sessions.

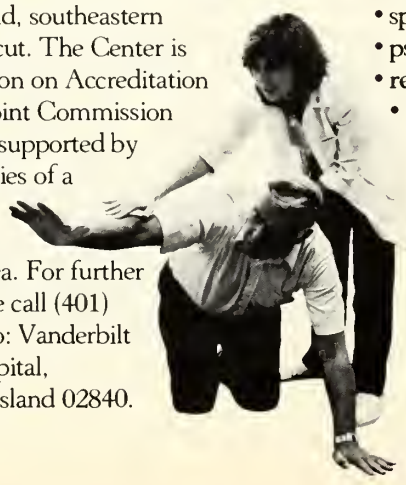


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Volume 69, 1986

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EDITORIALS

The Doctor's Dilemma 1986 — Short-Term vs Long-Term Considerations in a Changing Health Care Field

Since submission of this Editorial, the following events have occurred: 1) A number of physicians disaffiliated from Blue Shield, Ocean State Physicians Health Plan or both. 2) Blue Shield has ostensibly hardened its position by indicating that if a physician disaffiliates with Blue Cross/Blue Shield and remains affiliated with Ocean State Physicians Health Plan, it will decrease by 20 per cent the reimbursement to the patients. 3) Suit has been filed by Ocean State Physicians Health Plan against Blue Cross/Blue Shield alleging anticompetitive activity and anti-trust behavior. 4) Blue Cross/Blue Shield has appreciably increased insurance premium dollars.

Rhode Island has always been one of the most noncompetitive health insurance states in the country. Blue Cross and Blue Shield of Rhode Island has provided coverage for 80-90 per cent of eligible participants within the state for the last 20-30 years, and, for whatever reasons, no other insurer has challenged its position. Further, the state's health care system has been highly regulated. Expansion of existing services and the development of new ones have been tightly controlled by both the legislature and the state health department. This combination of circumstances has either prevented, delayed, or substantially modified the provision of new services. In addition, reimbursable physician fees have been much lower when compared to those in neighboring states. Benefits for medical subspecialists, concurrent care, follow-up care or follow-up consultations have never been provided by Blue Shield. The presence of the only prepaid closed panel health maintenance organization (HMO), the Rhode Island Group Health Association (RIGHA), has had a relatively small market penetration over the past 10-15 years, and has not been perceived as a threat by either Blue Cross/Blue Shield or the practicing physician.

In 1983, a statewide Independent Practice Association (IPA) fee-for-service HMO (Ocean State Physicians Health Plan) began operation. Its unparalleled growth to over 80,000 subscribers demonstrates both physician and patient desire for and acceptance of an alternative to existing insurance programs. The intent of the founders of this HMO was for continued free access fee for service care. Unfortunately, the Plan entered the marketplace with few constraints upon either physicians or patients, which has led to a very high level of utilization of services. In order for the plan to survive and succeed, both patients and physicians must assume more responsibility for their actions. This does not in any way imply alteration in quality of care or reduction in availability of services. Alternatively, the judicious use of less expensive services, ie, office visits instead of emergency room visits, under the direction of physicians can result in savings without compromising care. Finally, hospitals must also be brought into the process as participants who are concerned about costs while also maintaining or increasing their market share.

The initial Blue Cross/Blue Shield response to competition was one of disregard. In 1985, when Ocean State Physicians Health Plan had 40,000-50,000 members, Blue Shield planned to develop its own capitated gatekeeper HMO. In June of 1986 however, Blue Cross/Blue Shield adopted a new plan of attack. This plan was neither to increase premium dollars because for the first time there was a competitor on the scene, nor to decrease consumer benefits (rather they were increased), but to decrease physician fees and in addition to make physicians choose between Ocean State Physicians Health Plan and Blue Shield participation. It is beyond the scope either of my expertise or of this Editorial, to discuss the legal, economic, and moral aspects of this situation. Suffice it to say that these matters will be adjudicated over the next several years at great expense to everyone, including the consumer.

While the insurance companies do battle, the physician is caught in the middle. Malpractice insurance premiums continue to rise. The cost of doing business continues to rise. Medicare reimbursement, a major portion of the income of most physicians, while not affected at all by the local controversies is either capped, increasing too slowly, or in the case of some specialties even decreased. Frustration and hostility among physicians is high, and a variety of options are

being explored. In making decisions one must weigh the short-term against the long-term. In the short term, not participating in Ocean State Physicians Health Plan may result in a small acceptable financial loss, but may compromise for the future any leverage with Blue Cross/Blue Shield. This will not be an easy decision for many individuals. The overriding fact remains that health-care premium dollars are not increasing fast enough to assure physicians increased income in line with rising costs or even to sustain present income.

This dilemma is not easily soluble, nor is the same answer correct for each individual. All that one can expect is that, if reasonable people look at the facts unemotionally, they will make rational judgments that will serve them for both the short and long terms. This is a difficult but interesting and exciting time to be involved in medicine. We should not shun our responsibilities to our patients, and should assume some responsibility for the cost of medical care. Rhode Island physicians are in a critical situation, and their individual decisions will be the determining factor as to how this scenario plays out.

Joseph A. Chazan, MD
Medical Director
Ocean State Physicians Health Plan

The Rhode Island Medical Society Library — A Valued Treasure

In the November 1986 issue of this *Journal*, Helen DeJong, Librarian Emerita of the Rhode Island Medical Society, described some of the special treasures of the Society's library. She told of the foresight and devotion of a small group of distinguished and foresighted members who put together this valued collection in the early years before and after the turn of the century — Doctors George D. Hersey, James Henry Davenport, and Herbert Graves Partridge, among others — who worked diligently to fill the shelves of the then new library building, built seventy-five years ago and completed in 1912.

The fate of the library in recent years has been precarious because of the fiscal problems of the Society. Usage of the library has declined, affected by the growth of hospital libraries pursuant to their educational programs.

The library serves a number of useful purposes in addition to its availability to members. It has many historically valuable volumes accessible nowhere else in the state. It receives periodicals from exchanges through the *Rhode Island Medical Journal* of journals from the four corners of the world. It is a valuable, most indispensable resource for the *Journal*. It is a rich resource for the community, with full access unavailable at such repositories as the libraries at Brown University, and contains volumes not in any case available at that institution. It is a resource used by many special groups in the community — lawyers, reporters, insurance underwriters, high school and college students, and a variety of scholars. It also provides Medline services with access to the National Medical Library.

Some two years ago an important little-publicized survey of the library was made by a distinguished authority in the field, Richard J. Wolfe, Curator of Rare Books and Manuscripts in the Francis A. Countway Library of Medicine of the Harvard Medical School and Joseph Garland Librarian of the associated Boston Medical Library. Some of his comments are relevant:

"I would recommend that for the time being the Society hold on to these collections. I found that they are excellent from the viewpoint of studying medical history, and that such a collection could not easily be built again except through long and continuing effort and great expense. While parts of them, the older monographs for example, could be sold or auctioned, such a sale would probably realize only a fraction of their value, perhaps $25,000 or $50,000, and only a small part of the collection could be disposed of in this way. The vast majority of materials would prove difficult to dispose of by sale, and the Society would probably still be left with the larger part of its collections and its problems, and this after the most significant part of the collection had been removed. Inasmuch as the *Rhode Island Medical Journal* is edited at the Society's headquarters, this seems justification enough for retaining these collections."

Wolfe continued:

"In summation, I found that Rhode Island Medical Society owns a small but very fine historical collection, one which is on a par with some universities conducting programs, including

graduate programs, in medical history; that such a collection has been built up over a century-and-a-half and reflects the collecting interests and tastes of some of Rhode Island's outstanding medical personalities — Usher Parsons and Charles V. Chapin, for example — and that such a collection could not be assembled again at this late date, and, therefore, great care should be exercised in reaching a decision regarding its future. I would like to see this collection remain in Rhode Island to serve as a resource for the teaching and study of medical history there."

While the main emphasis of the Society at the moment is on fiscal and socioeconomic problems, this has not always been so. In the past there was much interest in the scholarly pursuits, and there may be again in the future. The Society must guard against a posture that may be interpreted as anti-intellectual. If these valuable collections are eventually dispersed, it will be impossible as with Humpty-Dumpty to put it back together again. Wolfe stated that he hoped that the collection might retain its identity, that it be dynamic and not merely a relic of the past, and that it serve as a resource for the study of medical history in Rhode Island.

The Society has an obligation, both historical and moral, to itself and to the community to accomplish this goal. It must avoid a hasty decision that its members at some future time will regret.

Seebert J. Goldowsky, MD

Coming Anniversary

Nineteen-eighty-seven will be a signal year in the history of the Rhode Island Medical Society — the 75th anniversary of the building of the Society's handsome library constructed in 1912 and the 175th anniversary of the founding of the Society itself in 1812.

This double anniversary calls for more than a routine notice of the event. The 150th anniversary in 1962 was celebrated by a very successful health fair lasting several days held at the monumental old Cranston Street Armory and by the publication of a history of the first century-and-a-half of the Society together with historical accounts of the district associations. There was much good will and many favorable comments generated by the fair, which was partially financed by several businesses in the community.

Little time can be wasted if a suitable celebration is to be mounted in 1987 — in fact the time is already late.

This writer would suggest that a fair late in '87 should be seriously considered. Not only will it profit the community as an educational exercise, but it will accrue to the benefit of the Society as a public relations venture. Because of its educational nature grant funds may be available.

Let the House of Delegates and the Council of the Society give heed to this special opportunity.

Seebert J. Goldowsky, MD

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Providing medical-care continues to be increasingly complex. Technology changes rapidly, and our practices become more specialized. In our ever changing profession we are challenged constantly to assure that we perform at the highest possible standards. A provider's performance that falls below acceptable standards results primarily from one of three reasons: impairment, competency, or unprofessional conduct. The Rhode Island Medical Society has accepted the responsibility of monitoring physician performance by establishing three standing committees. These are the Committee on Impaired Physicians, the Peer Review Committee on the Competency of Physicians, and the Mediation Committee. These committees play an essential role on behalf of both the doctors and the public, but their actions go relatively unnoticed.

The Committee on Impaired Physicians is charged with providing aid and assistance to doctors whose judgements and abilities are affected by illness. This committee helps physicians receive treatment for conditions such as chemical dependency, behavioral disorders, and senility. These illnesses if left untreated may become serious enough to impair physicians' judgements and endanger their patients.

Doctors, families, patients, and others are encouraged to report cases where impairment is suspected. If the evidence warrants the involvement of this committee and the doctor has failed to seek the necessary treatment, the committee proceeds with appropriate action. It will become the physician's advocate by offering compassionate, comprehensive, and confidential aid. When necessary it will refer the individual to specialists for diagnosis and treatment. The progress of each case is monitored, and the committee supports the recovering physician in resuming a full practice.

The success of this committee is recognized and respected. Eighty-five per cent of chemically dependent physicians assisted by the Impaired Physicians Committee have returned to a normal practice.

The Peer Review Committee on Physician Competency was created to consider cases where the level of a physician's performance has been questioned. Written complaints from physicians, patients, state agencies, or insurance carriers are some of its sources of information. The committee may recommend refresher courses, remedial education, and other courses of action deemed appropriate.

In cases where the Health Care Review, Inc of Rhode Island (HCRI, the professional review organization) suspects incompetency, details are in the works to allow the committee in conjunction with HCRI to help the physician. This will be done before the matter escalates to a level of seriousness which warrants the attention of the federal government.

The Mediation Committee considers matters of unprofessional conduct and addresses ethical questions independent of medical competence. This committee investigates cases where physicians knowingly practice below acceptable standards. Many of these cases can be resolved by peer pressure. However if the unprofessional conduct appears to be serious enough, it is referred to the appropriate state agency.

The success of most cases before these three committees is dependent upon the extent of cooperation by the physician in question. The committees have been created to aid physicians in overcoming difficult circumstances while ensuring that the highest quality of health-care is provided in this state. In matters where the physician in question refuses to cooperate with the appropriate committee, there is no alternative other than to refer the matter to the state disciplinary panel.

The doctors that makeup these committees are all volunteers. The time and effort devoted by these members addressing this responsibility deserves recognition. Because of their special commitment both the public and the doctors are better served, and the number of bad outcomes reduced. This Society and all other citizens of Rhode Island owe these dedicated doctors our sincerest appreciation. If they can help you or someone you know please contact them at the Rhode Island Medical Society.

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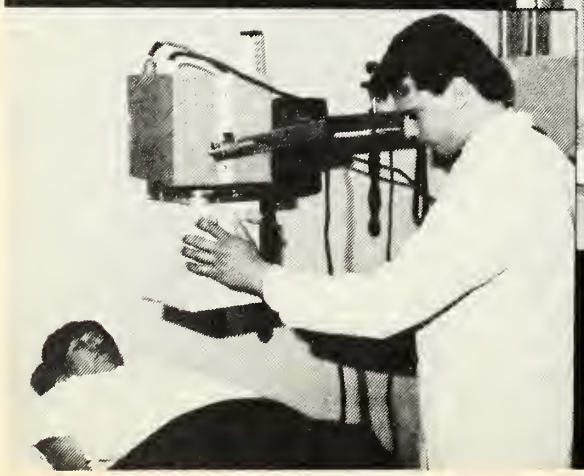
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TRIBUTE

An Appreciation of Bencel L. Schiff, MD

Presented at the New England Dermatological Society meeting of April 26, 1986.



Bencel L. Schiff, MD, 1909-1985

Bencel L. Schiff died November 15, 1985, his passing, in a sense marking the end of an important era in the history of Rhode Island dermatology. He was a dynamic man who in many ways touched the lives and hearts of innumerable individuals in the New England community.

Born in Seda, Lithuania in 1909, he graduated from the University of Montpellier, France with a Bachelor of Science degree in 1928 and a medical degree in 1932. Following graduation he moved to the United States and did a rotating internship from 1932 to 1933 at St. Joseph's Hospital, Lancaster, Pennsylvania. His training in dermatology commenced with a residency at Philadelphia's Skin and Cancer Hospital from 1934 to 1937 and was followed by a residency in malignant disease at the New York City Cancer Institute in 1938 and 1939. Deeply concerned by the deplorable situation in Europe at the time, in 1940 he enlisted in the military, achieving the rank of Lieutenant Colonel as a Flight Surgeon in the United States Army Air Force. Upon his discharge after five years of military service, he took additional dermatologic training with a year at Bellevue Hospital, New York City, followed by a year at the Boston City Hospital. In 1947 he was certified by the American Board of Dermatology.

That same year he commenced private practice in Pawtucket, Rhode Island, continuing without interruption until his death. During these 38 years he cared for thousands of residents of Rhode Island, Massachusetts, and Connecticut, both in his office and at the many clinics to which he devoted his time. In 1950 he was appointed an instructor in the Department of Dermatology at Boston University School of Medicine by John Downing, then department chairman. He played an important role in the development of this then small department, continuing to do so after the late Herbert Mescon became its chief. The department of Dermatology at Boston University became one of the major ones in the country. In recognition of his achievements in teaching, Doctor Schiff was promoted to the position of Associate Clinical Professor.

For many years he served as the head of the departments of dermatology at both the Pawtucket Memorial Hospital and the United States Veterans Administration (VA) Hospital in Providence. In 1970 when the Brown University Program in Medicine instituted a department of dermatology, he threw all his support behind this new program and its chief, Charles McDonald, and continued to work actively to make it a recognized leader in the training of medical students and dermatology residents. Initially appointed Associate Clinical Professor of Medicine (Department of Dermatology) he soon was promoted to Clinical Professor and finally to Clinical Professor Emeritus. Many graduates of the residency program will attest to the debt they owe

Doctor Schiff for his unstinting interest in them as individuals and for the invaluable lessons learned from him. A rotation at the VA Medical Center was one of the highlights of the residency, due to Doctor Schiff's dynamic personality and warmth.

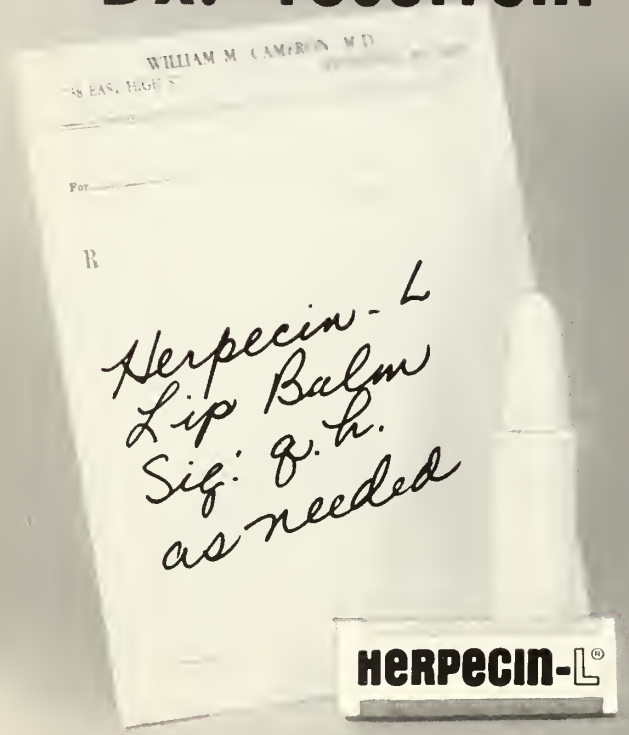
His inquisitive mind led him into many clinical investigations. He published 51 articles in the dermatologic literature between 1947 and 1982. His extraordinary role in medicine and particularly in the field of dermatology was recognized by his election to the position of president of the Pawtucket Medical Society, secretary and later president of the Rhode Island Dermatological Society, and treasurer and eventually president of the New England Dermatological Society.

A unique physician, he was no less remarkable as a son, brother, husband, and father. His concern for his parents, siblings, and relatives and his selfless giving to insure their well-being was outstanding. His devotion to his wife Edith, to daughter Susan, and son Barry, and the warmth and love that surrounded this small family were no less remarkable and served as a model that we have tried to emulate.

Bencel L. Schiff will long be remembered for his most important roles as practitioner, researcher, and teacher in the field of dermatology. He will be admired for his virtues as husband, father, and friend. Outspoken in his beliefs and with no tolerance for bigotry and hypocrisy he will forever be respected as a man who believed strongly and who spoke out without hesitation in support of those beliefs. He will be missed.

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8/30/85	James	Bal. Forward				60.-
9/3/85	" "	O.V	40.-	Billed 9/5/85		100.-
9/30/85		Medicare pmt/adj.		-46.-	-8.-	47.-
10/10/85		Patient pmt.		-7.-		40.-
10/25/85		Medicare pmt/adj.		-28.-	-5.-	7.-
11/10/85		Pt pmt.		-7.-		-0-
11/20/85	James	Int. O.V	40.-	Billed 11/21/85		40.-
12/5/85	James	surgery	800.-	Billed 12/20/85		840.-
1/5/86		Medicare pmt/Adj		-26.-	-5.-	807.-
1/17/86		Coord. adj.			-3.-	804.-
2/21/86		Medicare pmt/Adj		440.-	250.-	114.-

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2	2	86	Medicare Payment		440 00
2	2	86	Medicare Adjustment		250 00

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ACCOUNT NO 12090
STATEMENT DATE 02/21/86

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AMOUNT ENCLOSED $

ATTENDING PHYSICIAN'S STATEMENT

DIAG CODE	SERVICE DATE	PROCEDURE REFERENCE	PATIENT NAME	LOC	DESCRIPTION	CHARGES PAYMENTS ADJ PATIENT	INSURANCE
3624	11/20/85	9003	JAMES	0	INTERMEDIATE EXAMINATION	40.00	
	01/05/86				MEDICARE PAYMENT	-28.00	
	01/05/86				MEDICARE ADJUSTMENT	-5.00	
	01/17/86				NO CO-INSURANCE PAYMENT	0.00	
	01/17/86				COURTESY ADJUSTMENT	-3.00	
	MEDICARE AND CO-INSURANCE HAVE PAID THEIR PORTION OF THIS CLAIM. THE BALANCE IS YOUR RESPONSIBILITY. PLEASE REMIT.						
3624	12/15/85	5637	JAMES	IH	SURGERY		800.00
	02/02/86				MEDICARE PAYMENT		-440.00
	02/02/86				MEDICARE ADJUSTMENT		-250.00
	AWAITING CO-INSURANCE PAYMENT						
	YOUR BALANCE HAS BECOME PAST DUE. PLEASE REMIT.						

CURRENT	OVER 30 DAYS	OVER 60 DAYS	OVER 90 DAYS	OVER 120 DAYS	NEW BALANCE	PATIENT	INSURANCE
.00	4.00	.00	.00	.00		4.00	110.00

ANALYSIS OF PATIENT NEW BALANCE

PATIENT IS RESPONSIBLE FOR "PATIENT NEW BALANCE" SHOWN.

STATEMENT DATE	PATIENT PAY Y T D	ACCOUNT NUMBER
02/21/86	.00	12090

LOCATION CODES
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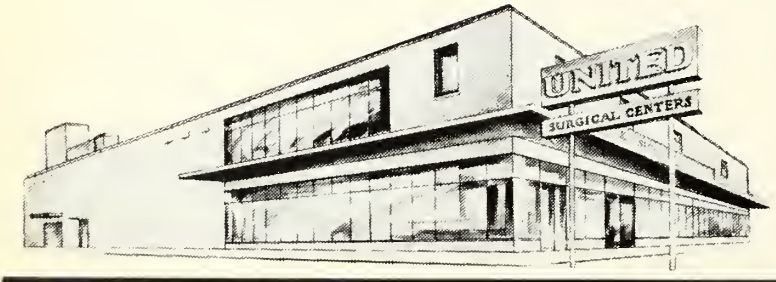
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Clinicopathological Conference

Thomas Jones, MD
Enold Dahlquist, MD
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An 81-year-old white female presented to her physician with three weeks of progressive weakness and myalgias.

She had been well until six months before admission when she developed a persistent cough productive of whitish sputum. Three weeks before admission she experienced the onset of fatigue, weakness, muscle aches, and anorexia. Two weeks later she was unable to stand up from a chair without assistance. Three days before admission she developed intermittent nausea and vomiting. She denied fever, chills, arthralgias, headaches, chest pain, shortness of breath, diarrhea, or gastrointestinal bleeding.

Her past medical history was significant for hypertension treated with hydrochlorthiazide, and chronic anxiety treated with Triavil® (perphenazine and amitriptyline) and butabarbital. She had received desensitization injections for allergic rhinitis for several years, ending in the recent past. She denied allergies to medications, use of alcohol, or tobacco, toxin, or infectious exposure. She was married and had always been a homemaker.

On examination the patient was a pale, thin elderly white female. Her temperature was 102°F rectally, respirations were 18, and pulse was 100. Blood pressure was 170/70, and there were no orthostatic changes. There were no rashes or skin lesions. Head and neck were normal. No lymphadenopathy was detected. There were no masses on breast examination. Slight bibasilar crackles were noted on chest auscultation. The heart was normal except for a Grade II systolic murmur at the left sternal border with radiation to the carotids. Abdominal examination was negative, and on rectal examination revealed stool was negative for occult blood. No atrophy or deformities of the extremities was noted. Neurologic examination revealed normal mental status, and normal reflexes, cerebellar function, and sensory function. Strength was 3/5 proximally and 4/5 distally in all extremities.

Serum sodium was 126 mEq/l, potassium 4.5 mEq/l, chloride 86 mEq/l; and carbon dioxide 22 mEq/l. Urea nitrogen was 24 mg per 100 ml, creatinine 1.3 mg per 100 ml. Hemoglobin was 10.0 gm per 100 ml, hematocrit 30.4 per cent, and white cell count 10,400 with 83 per cent neutrophils, 11 per cent lymphocytes, 5 per cent monocytes, 1 per cent eosinophils (hemoglobin reportedly was "normal" two months before admission). Mean corpuscular volume was 81 Fl m^3, reticulocyte count 1.2 per cent, erythrocyte sedimentation rate 59 mm per hour. Iron was 22 mg per 100 ml, iron-binding capacity 118 mg per 100 ml, ferritin 400 ng per ml, and haptoglobin 400 mg per 100 ml. Lactic dehydrogenase was 466 U per ml, serum aspartate amino transaminase (SGOT) 22 U per ml, creatinine phosphokinase 29 mU per ml, alkaline phosphatase 100 1U per liter, Bilirubin was 0.3 mg per 100 ml. Total protein as 5.6 gm per 100 ml, albumin 2.6 gm per 100 ml, Calcium was 8.8 mg per 100 ml, magnesium 1.5 mg per 100 ml, phosphorus 2.9 mg per 100 ml. Thyroxine was 5.7 mg per 100 ml; triiodothyronine resin uptake was 31.4 per cent, thyroid-stimulating hormone 8.8 mU per ml. Urine pH was 7.0, with 3-5 red cells and 6-10 white cells. Cultures of urine, sputum, and blood were negative. Rheumatoid factor and antinuclear antibody were negative. The chest x-ray studies and electrocardiogram were nor-

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mal. The patient was anergic on skin testing.

The patient was comfortable initially, but she remained weak and anorexic. Her temperature rose nightly to 102°F with no apparent reason. Abdominal ultrasound examination showed a right renal cyst. Abdominal and pelvic computed tomography (CT) scans showed a 6 cm cystic density mass behind the bladder on the right side of the pelvis, consistent with an ovarian cyst. Intravenous Pyelogram (IVP) showed extrinsic compression of the bladder by the mass. A surgical procedure was then performed.

Discussion: *Tom Wachtel, M.D., Department of Medicine*

Summarizing this case, the patient is an 81-year-old white female who developed an illness three weeks prior to admission, characterized by progressive fatigue, weakness, muscle aches, and anorexia. She had a productive cough six months preceding hospitalization, but before that was reportedly well except for hypertension and anxiety. During her acute illness she became so weak progressively that she was unable to stand from a chair by herself. She also experienced numerous gastrointestinal complaints. She never reported fever, chills, or diaphoresis, but was febrile throughout her hospital course. Therefore, fever was probably present before admission.

Her examination revealed muscle weakness more prominent in proximal groups. Muscle tenderness or pain on active contractions was not reported. There was no muscle atrophy, and the absence of deformity implies that muscle swelling was not present. The only other positive finding was a murmur. Laboratory evaluation revealed a normocytic nonregenerative anemia with an iron saturation of 13.6 per cent, and elevated ferritin and haptoglobin. The sedimentation rate was high (59 mm per hour). Lactic dehydrogenase was slightly increased, but liver, renal, and thyroid functions were all within normal range. Albumin was decreased, and significant hyponatremia was present. Calcium, magnesium, and phosporus were all normal. All cultures were negative. Radiologic examinations revealed a right ovarian cyst, a right renal cyst and a normal chest x-ray.

The patient has three major problems that warrant in-depth consideration: the inflammatory process, the muscle weakness, and the ovarian cyst. There is ample evidence that an inflammatory process is present, with the patient's constitutional symptoms, elevated sedimentation

Table 1. Causes of Fever of Undetermined Origin

Category	Number of Cases	
	Second Series (1970-80)	First Series (1952-57)
Infections		
Abdominal abscesses (including liver and biliary tract)	11	11
Mycobacterial	5	11
Cytomegalovirus	4	0
Endocarditis	0	5
Other	12	9
Total	32	36
Neoplastic Diseases		
Lymphoma, leukemia and related malignancies	22	8
Solid tumors	11	9
No histologic diagnosis	0	2
Total	33	19
Collagen Diseases		
Rheumatoid arthritis	4	2
Vasculitis	4	2
Rheumatic fever	1	6
Systemic lupus erythematosus	0	5
Total	9	15
Granulomatous Diseases (Sarcoidosis)	8	4
Miscellaneous	7	16
Factitious Fever	3	3
Undiagnosed	13	7
Grand Total	105	100

rate and the rise in acute phase reactants such as ferritin and haptoglobin. Furthermore, we can infer, based on what is known about her anemia, that this inflammatory process is chronic. Although the exact criteria for the diagnosis of fever of unknown origin (FUO) are not met (3 weeks of evaluation), the patient's presentation does fit this general clinical picture.[1]

With advances in medical technology, it is not surprising that the relative importance of the various causes of FUO has changed since the 1950s, as described by Larson, Featherstone, and Petersdorf[2] (Table 1). In the 1970s, the proportions of infectious and collagen-vascular causes are smaller, while there is relatively more neoplasia. Endocarditis has disappeared as a cause, likely because routine blood cultures are performed in febrile patients with or without heart murmurs, and possibly because of a more judicious use of antibiotics by physicians. Tuberculosis has decreased, but remains on the list. Cytomegalovirus is a newcomer, primarily because of our recent ability to make this diagnosis. Lupus has lost its place on the list with the use of the very sensitive antinuclear antibody (ANA) test for screening, rather than the more specific but relatively insensitive lupus erythematosis (LE) cell preparation used in the 1950s and 1960s. The greater contribution of malignant disease is largely an indirect result of the decrease in other causes. Which of these diagnoses might fit this patient? The patient is very unlikely to have an abdominal abscess. She had no predisposing illness such as appendicitis, cholecystitis, or diverticulitis. The CT scan, which is generally quite sensitive in making this diagnosis, failed to show the presence of an abscess. Furthermore, the course of events, and her examination are not suggestive of an abdominal abscess.

Cytomegalovirus (CMV) infection can produce cough and other symptoms of pneumonia. Other clinical manifestations include a petechial rash, splenomegaly, hepatomegaly, abnormal liver function tests, and a mononucleosis-like syndrome of malaise, fever, chills, myalgias, sore throat, headache, anorexia, abdominal pain, lymphadenopathy, and splenomegaly. Atypical lymphocytes are usually found in the blood. Because of the patient's age and the duration of her pulmonary symptoms, she almost certainly does not have CMV infection, but appropriate serologic tests would be needed to exclude this diagnosis.

Despite the association of murmurs with fever, it is unlikely that she has bacterial endocarditis (BE), because the blood cultures were negative and no associated signs are present. Furthermore, there is no evidence to support any of the causes of culture negative endocarditis, such as prior antibiotic use, right-sided BE, bacteria with special growth requirements, uremia, and nonbacterial infections.[3]

There are several other infections in the differential diagnosis, including osteomyelitis, amebic abscess, candidiasis, psittacosis, brucellosis, and various viruses. Again, there is nothing in the patient's presentation to support these diagnoses.

Although the contribution of tuberculosis as a cause of FUO has decreased, it still occurs, and often the diagnosis is difficult to establish.[4] This patient's chest x-ray film is normal, ruling out classic pulmonary tuberculosis. Extra-pulmonary disease must be considered, including miliary and urogenital forms.

The symptoms of miliary tuberculosis[5] include weakness, anorexia, weight loss, fever, and cough; all were described by this patient except weight loss. Physical findings include fever, tachycardia, tachypnea, pulmonary auscultatory abnormalities, hepatomegaly, splenomegaly, and nuchal rigidity. This patient is described as having only fever and borderline tachycardia. She was also anergic, which is consistent with, but not specific for, miliary tuberculosis. Furthermore, the vast majority of patients have a miliary pattern on chest x-ray study, a finding which was not described in our case.

With the presentation of an abnormal urine sediment, a right renal mass by ultrasound, and a right adnexal mass on CT scan, urogenital tuberculosis must be considered. It was not clear from the protocol why the abdominal ultrasound and pelvic CT were done, but it may have been to follow up the abnormal urinalysis. The differential diagnosis of culture-negative pyuria and microscopic hematuria warrants mention. It includes, for example, nonbacterial infections such as tuberculosis, neoplastic lesions of the kidney and bladder, nephrolithiasis, and interstitial nephritis. The lesion found on ultrasound examination was described as a renal cyst. Ultrasonography is extremely accurate in differentiating between cysts and cancer.[6] The intravenous pyelography failed to show any additional intrinsic lesions of the kidneys or collecting system, essentially ruling out urinary tuberculosis. A complete work-up should include urine cultures for acid-fast bacilli to rule out occult urinary involvement as part of miliary tuberculosis. In contrast with the situation in males, urinary and genital

tuberculosis in women are often unrelated because both result from independent hematogenous spread. An adnexal mass is consistent with tuberculosis of the reproductive organs. There is some support in the literature for the use of the laparotomy to rule out tuberculosis in patients with solid adnexal masses. It is unlikely that the cystic lesion in this patient is tuberculosis because granulomas are generally solid lesions. Furthermore, the patient does not have any of the symptoms of genital tuberculosis.[7] In summary, tuberculosis is unlikely; however, it would have been prudent to have obtained appropriate cultures (morning sputums, urine, and possibly bone marrow). Of additional interest in relation to tuberculosis is the observation that this patient is hyponatremic and has a small cardiac silhouette, both of which are signs of Addison's disease. In the past, the most common cause of Addison's was tuberculosis. However, in this instance the hyponatremia is better explained by diuretic use, especially with the accompanying elevation of the bicarbonate level. While the abdominal complaints are consistent with Addisonian crisis, the hospital course without steroid therapy rules this out.

The question arises as to whether the patient could have a malignant disease as the cause of her fever and other symptoms. Many cancers can cause fever, but most commonly it is seen with lymphoma and renal cell carcinoma. Referring to the previous discussion of the renal cyst, renal cell carcinoma has been ruled out. This patient could have a lymphoma, but the protocol gives no clues as to its whereabouts. Previously, it was mentioned that a bone marrow aspiration and biopsy should be performed to rule out tuberculosis completely. Another indication for bone marrow examination is suspicion of malignant disease in a patient who is also anemic.

The right adnexal mass must again be considered in the context of discussing a possible malignancy. While tuberculosis is not likely to present as a cystic lesion, the same cannot be said of ovarian cancer. Cystadenocarcinoma can present clinically as a cyst, and the diagnosis is made by survical removal of the lesion. Only 3 per cent of ovarian lesions less than 5 cm in diameter are malignant, compared with 15 per cent of lesions greater than 5 cm. Precise recommendations for surgery in patients with an adnexal mass have been published[8] (Table 2). This patient needs an exploratory laparotomy as part of her work-up, regardless of the odds that the adnexal lesion is malignant.

Table 2. Indications for Exploratory Laparotomy

Prime indications for doing exploratory laparotomy are:

- Any pelvic mass that has appeared after the menopause, particularly an adnexal mass;
- An adnexal mass in a woman of any age that progressively enlarges beyond five cm while under observation;
- An adnexal mass 10 cm or more in size (functional cysts seldom get this large);
- A mass that cannot be definitively diagnosed as either a fibroid or carcinoma.

Immune disorders should now be considered. The negative antinuclear antibody essentially rules out systemic lupus erythematosus because the sensitivity of the antinuclear antibody is greater than 95 per cent, and thus there are few false negative tests. In order to consider the diagnosis of antinuclear antibody negative lupus, the patient would have to present with typical clinical findings, which is not the case. There are no clinical manifestations of rheumatoid arthritis either. With a negative rheumatoid factor, there should be some joint complaints to warrant consideration of this diagnosis. Still's disease generally occurs in young women, and a rash is commonly present.

The diagnosis of sarcoidosis is also very unlikely. She has none of the features of sarcoidosis (Table 3) except the general symptoms of inflammation.

The vasculitides (eg, polyarteritis nodosa) must also be included in the differential diagnosis of FUO. Once again, however, this patient does not have any of the relevant clinical findings of this

Table 3. Signs of Sarcoidosis

Manifestations
Peripheral lumph nodes
Lungs
— Hilar and mediastinal changes
— Parenchymal changes
Liver involvement
Skin involvement
Spleen involvement
Eye involvement
Neurological involvement
Anemia
Leukopenia
Eosinophilia
Hypoalbuminemia
Hyperglobulinemia
Hypercalcemia

group of diseases, such as skin rash, glomerulonephritis, mononeuritis multiplex, pulmonary infiltrates, or central nervous sytem involvement. Therefore, polyarteritis nodosa and its variants are unlikely.

The patient's muscle complaints are better defined and consist primarily of soreness and weakness. Apparently there is no atrophy, deformity, or swelling present. Abnormal muscle function can be classified by the site of the primary disease process. Examples are upper motor neuron (as in strokes), lower motor neuron (as in amyotrophic lateral sclerosis), peripheral neuropathy (as in diabetes), neuromuscular junction (as in myasthenia gravis) and the muscle itself. The combination of a proximal distribution of weakness and muscle pain leads to a strong consideration of a primary muscle disease. Myasthenia gravis and related disorders can be ruled out because they do not cause myalgia. The muscular dystrophies can be ruled out because of the patient's age and the complaint of myalgia rather than cramps.

There are several acquired diseases of muscles including polymyositis/dermatomyositis, polymyalgia rheumatica, sarcoid myopathy, infections, and metabolic myopathies. This last category includes thyrotoxicosis, alcoholism, hypophosphatemia, and periodic paralysis. Infections that can directly involve muscle include bacteria (staphylococcus, streptococcus, and miliary tuberculosis), parasites (trichinosis, cysticercosis, and toxoplasmosis), and viruses (influenza and coxsackie). Sarcoidosis was previously discussed and excluded. There is little evidence to support any of the infectious causes. Finally, the metabolic myopathies generally do not cause myalgias and are thus unlikely in this patient.

Two clinical entities deserve closer attention at this point. These are polymyalgia rheumatica and polymyositis.

In favor of polymyalgia rheumatica are the patient's sex and age, the elevated sedimentation rate, the myalgias, and the normal muscle enzymes. Table 4 is a listing of common clinical manifestations.[9] The presence of weakness and the absence of morning stiffness are against this diagnosis. While it is true that testing muscle strength in the presence of pain may falsely lead to an impression of weakness the protocol information does not support polymyalgia rheumatica. Normal electromyography and muscle biopsy would be expected.

Polymyositis is more likely in this patient.[10, 11] In favor of this diagnosis are the combined presence of myalgias and weakness and the tendency of this disease to occur more often in women and the elderly. Fever is not commonly described as a feature, but with significant muscle tissue destruction, a fever might be present. The negative muscle enzymes must be considered. While most patients have elevations of CPK and SGOT in the course of the disease, as many as one-third will have normal enzymes at the time of presentation. A small percentage of patients have an accompanying interstitial pneumonitis. An association between polymyositis and malignancy has been described in the literature.[12] This association probably exists only with dermatomyositis; so the presence of skin findings is very important. These include a heliotrope rash or dusky discoloration of the eyelids, Gottron's papules, periungual telangiectasia, and poikiloderma with a photodistribution. This patient has none of them. This patient actually meets only the criteria of progressive symmetrical and proximal muscle weakness (Table 4). She did not have electromyography or a muscle biopsy.

There are two final possibilities in the differential diagnosis to be mentioned. First, factitious fever should not be excluded on the basis of the patient's age. Octagenarians are probably as likely to fake illness as younger people, but this patient has enough objective findings to exclude Munchausen's syndrome. Second, iatrogenic illness should be considered, particularly the possibility

Table 4. Criteria for Diagnosis of Dermatomyositis-Polymyositis

- Progressive symmetrical proximal muscle weakness
- Muscle biopsy consistent with myositis
  - Fibre necrosis
  - Regeneration
  - Sarcolemmal nuclei (centralization)
  - Inflammatory infiltrate
  - Perifascicular atrophy
- Elevated muscle enzymes (CPK, SGOT, LDH, aldolase)
- Abnormal electromyogram
  - Positive or sharp waves
  - Insertional irritability
  - Fibrillations
  - Short polyphasic motor units
  - Lack of neuropathy
- Cutaneous disease
  - Heliotrope
  - Gottron's papules
  - Photodistribution of poikiloderma
  - Periungual telangiectasias

of drug-induced symptoms. The hydrochlorothiazide is the most likely cause of her hyponatremia. Both barbiturates and the phenothiazines can cause fever. Barbiturates can cause myalgia, and amitriptyline, because of its anticholinergic properties, can cause muscle weakness. Furthermore, allergic reactions to any of these drugs can cause inflammatory signs.

In conclusion, my diagnosis is polymyositis associated with ovarian cystadenocarcinoma. Additional diagnostic work-up should include electromyography followed by muscle biopsy if the electromyogram shows a myopathic picture, a bone marrow biopsy (with cultures for tuberculosis), sputum and urine specimens for acid-fast bacteria, and an exploratory laparotomy.

Pathological Discussion: *Alfredo Esparza, MD*
The specimen consisted of a uterus with bilateral adnexae and an appendix. There was a left ovarian cyst, 7 cm in diameter and filled with clear fluid; microscopically this corresponded to a serous cystadenoma. The uterus was small, 34.5 gm and measured 7 × 5 × 2.5 cm. There were no external abnormalities. The serosal surfaces of the uterus, tubes, and ovaries were unremarkable. There was a small, sessile endometrial polyp. The microscopic study, however, revealed striking and unsuspected changes. There was evidence of a widespread necrotizing arteritis involving both ovaries and tubes as well as the body and cervix of the uterus. Nearly all arteries of medium size were affected. Acute necrotizing lesions were prevalent, with extensive areas of fibrinoid necrosis, often circumferential. In some vessels the necrosis was limited to the intima, but in others involved the media with destruction of the internal elastic lamina. A marked inflammatory infiltrate was noted in the vessel walls extending into the adventitia and surrounding stroma. The infiltrate consisted of polymorphonuclear leukocytes and mononuclear cells, especially histiocytes. Eosinophils were present, but in rather insignificant proportions. In some arterioles the inflammatory reaction revealed a granulomatous appearence with epithelioid and multinucleated giant cells. Changes of healed and healing vascular lesions were also present, although not numerous.

The changes above-described are those of the "classic" form of polyarteritis nodosa. Since polyarteritis is a systemic disease, it is not unusual to make the diagnosis on an incidental surgical specimen unrelated to the patient's basic disease process. The involvement of the uterus and adnexae, however, is uncommon, contrary to the gonadal involvement in the male. The lack of symptoms attributed to the reproductive organs in this patient is not surprising because, in general, there is little correlation between signs and symptoms and the actual organ involvement by necrotizing vasculitis.

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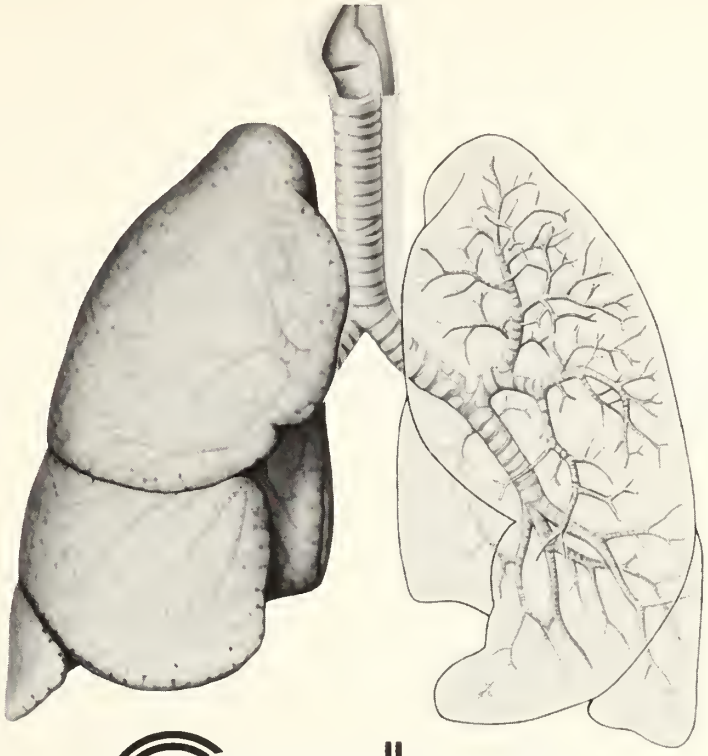
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Program Appears to Provide Significant Savings

Norman A. Campbell, JD, PhD, RPh
Anthony W. DiLorenzo, JD, RPh
Charles Hachadorian, Jr, MPA, RPh
H. Denman Scott, MD, MPH

In 1976, following the lead of several other states, the Rhode Island General Assembly passed a drug product selection (DPS) statute, thus permitting pharmacists for the first time to engage in brand interchange. The "DPS law" consists of a variety of provisions in applicable sections of the *General Laws of Rhode Island* and in *Rules and Regulations Pertaining to Drug Product Selection* promulgated by the Director of Health.

Legal Provisions

The use of a prescription slip containing two signature lines is mandated by the following provision:

> *Prescription Slips.* — Every prescription slip issued by a physician shall contain the clearly-printed name and address of the issuing physician. In addition every prescription written in this state shall have two (2) lines for the practitioner's signature. Under the first line shall be the words "Substitution Allowed." Under the second line shall be the words "Dispense As Written." By signing one (1) of the two (2) lines the practitioner has indicated to the pharmacist his dispensing instructions. The requirements of this section and of §5-37-18.1 shall not apply to an order to dispense a drug for immediate administration to a hospital inpatient.[1]

The provision alluded to in the practice act mandates that in the absence of certain conditions the "Substitution Allowed" line be signed:

> *Physicians Required to Authorize Product Selection.* — Every licensed Rhode Island physician, when prescribing any drug by brand name, shall in each such prescription, oral or written, authorize a less expensive generic equivalent drug product by signing on the line marked "Substitution Allowed" provided, however, that if in the professional judgment of the prescribing physician the brand name is medically necessary, the physician shall sign on the line marked "Dispense As Written" on the prescription form.[2]

The role of the pharmacist in DPS is defined in the following:

> *Pharmacists — Substitution of Drugs.* — Pharmacists when dispensing a prescription shall, unless requested otherwise by the purchaser in writing, substitute drugs containing the same active chemical ingredients of the same strength, quantity, and dosage form as that drug requested by the prescriber from approved prescription drug products in accordance with the provisions of section 21-31-16, unless ordered by the prescribing physician to

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dispense as written on the prescription form, or if the prescriber gives oral direction to such effect to the dispensing pharmacist. The requirements of this section shall not apply to an order to dispense a drug for immediate administration to a hospital in-patient. The pharmacist will make a product selection from approved prescription drug products and shall pass the savings on to the ultimate consumer, exclusive of the pharmacist's professional fee. The pharmacist may not charge a higher or different professional fee for the prescription drug product prescribed. When a drug product selection is made, the pharmacist shall indicate the product dispensed on the written prescription, or on the oral prescription, which has been reduced to writing.[3]

Several additional statutory provisions are significant:

The term "equivalent and interchangeable" means having the same generic name, dosage form and labeled potency; meeting standards of the United States Pharmacopeia or National Formulary, or their successors, if applicable, and not found in violation of the requirements of the United States Food and Drug Administration, or its successor agency, or the Rhode Island Department of Health.[4]

Annual Reports. — The Director shall make annual reports to the General Assembly by February 10 of each year showing a list of approved prescription drug products with therapeutic equivalence, and an estimate of the average savings to the general public.[5]

Pharmacists. — When a pharmacist dispenses a therapeutically equivalent drug product, there shall be no additional liability imposed on the prescriber who authorizes said product selection, or on the pharmacist dispensing said product selection from a physician's oral or written order.[6]

The original bill enacted by the legislature created a commission consisting of thirteen members which was charged with the task of creating a formulary from which pharmacists were to make their selections when engaging in authorized DPS. After five years of this model, the legislature repealed the commission provisions and authorized the Director of Health to appoint an Advisory Committee for Drug Product Selection for the purpose of recommending to the Director products deemed not to be therapeutically equivalent. Since January 1982, the only listing on the state's "negative formulary" is controlled release Anhydrous Theophylline.

These selected provisions quoted here provide background and a framework for consideration of the study conducted to measure the effectiveness of the DPS law and the extent of compliance with its provisions by members of the health care community in Rhode Island.

The annual reports of the Director of Health to the General Assembly for the years up to the study reported below were based in large measure upon the extrapolation of secondary and anecdotal data. This study was devised with the objective of documenting practice as it existed in November 1984 in Rhode Island, including an assessment of the magnitude of reduced expenditures, if any, for multi-source prescription drugs dispensed in community pharmacies in the state.

The Study

In October 1984, approximately two weeks prior to the beginning of the study, an educational and orientation program was conducted at a membership meeting of the Rhode Island Pharmaceutical Association. This program included a review of the current provisions of the state's DPS law and the proposed format of the study to be launched on November 1, 1984. Principal investigators of the project were on hand to answer questions from the audience about the study and provisions of the statutes and regulations, still unclear or misunderstood by some pharmacists.

In November 1984, a cover letter, instruction sheet, data collection forms and a return postage-paid envelope were mailed to each of the 212 licensed community pharmacies in Rhode Island. The principal investigators were a University of Rhode Island College of Pharmacy faculty member on sabbatical leave and a pharmacist-Pepperdine University Law School student on a legal clerkship, both at the Rhode Island Department of Health Division of Drug Control (DDC). Returns were sent directly to DDC. No means of identification were available to the researchers or enforcement personnel.

Pharmacists were asked to maintain a log of the next fifty new prescriptions filled in their respective pharmacies, providing certain information outlined on the form. Information was requested as to whether the required two-line prescription slip was used by the prescriber, and if so which line was signed. The pharmacist then indicated the name of the drug and whether or not a substitution had been made, and whether

the patient override provision was invoked. The name of the drug dispensed and of the labeler/manufacturer were also required. Under "Payment," the pharmacist was asked to specify whether private out-of-pocket, private insurance, or government program. Under "Charge Differential," the pharmacist was instructed to indicate the dollar value of the charge differential between what was charged when there was a substitution, and what would have been charged had the brand name product been dispensed.

Completed questionnaires were received before the deadline date from ninety-four (94) pharmacies, yielding information on a total of four thousand seven hundred (4,700) new prescriptions. This constitutes a response rate of 44.3 per cent.

Responses dealing with the level of use of the required two-signature line form indicated that 86.83 per cent of the prescription orders reported from participating pharmacies were executed on the required two-signature line form.

Since DPS can be effected only by the pharmacist when the prescriber so designates by signing the "Substitution Allowed" line, data were collected to determine the frequency of such authorization, whether a substitution were possible or not. No substitution is possible when the brand name product is a single-source product with no generic equivalent available. The law permits the patient to effect an override of the prescriber's authorization by insisting on the brand name product in writing. In the sample, 41.2 per cent of all prescriptions contained authorization for the pharmacist to substitute, whether or not substitution were possible.

Any assessment of direct impact of the statutory requirements upon patient cost savings would be predicated on the numbers and frequency of substitution actually made. Respondents were asked to report when such a step was taken, to identify the brand name product ordered, the specific product substituted, including the manufacturer or labeler, and the dollar differential. Of all prescriptions submitted, 12.7 per cent were substituted with a generic in compliance with the statutory provisions and rules and regulations.

An additional mechanism exists whereby pharmacists can select the actual product to be dispensed. Although not specifically mentioned in the DPS provisions, the pharmacist has the authority to determine which manufacturer's product to dispense when the prescriber uses the generic name of the drug. Such authority had been vested in the pharmacist long before the trend toward repeal of anti-substitution laws began across the country in the decade of the 1970s. Prescribers in the sample ordered 14.2 per cent of all prescriptions by generic name rather than by trade name.

While the DPS law does not address those prescriptions written by generic name, other factors in such cases are operative in the marketplace which substantially affect the patient charge. These factors include but are not limited to prescription drug advertising to the consumer, heightened consumer awareness, price competition, and price posting requirements for certain drug products. As a consequence, the combined total of actual substitutions made and the prescriptions ordered by generic name provides a clearer view of the influence on observed consumer cost savings, although no attempt was made to quantify these in financial terms. The overall total of all prescriptions in the sample which were actually substituted or were written by generic name amounted to 26.98 per cent.

As indicated, the "Substitution Allowed" line is signed by prescribers in many instances when substitution did not occur. Those situations were analyzed further to determine what did take place: written by generic name 34 per cent, single source products 47 per cent, patient overrides 4 per cent, and no substitution made 15 per cent. It is important to note, therefore, that while data presented above indicate a 12.7 per cent actual substitution rate, this figure must be considered with the other "Substitution Allowed" statistics to grasp the full impact of the statute.

Individual pharmacy reports of price differentials between what would have been charged for the brand name product specified by the prescriber and the selected generic equivalent were averaged and a mean figure computed for all pharmacies responding in the affirmative on such substitutions. The average consumer savings reported per prescription per pharmacy ranged from $0.70 to $12.70. The average dollar savings reported by pharmacies when a substitution was actually made amounted to $5.36 per prescription.

An effort was made to compare these results with other state studies reported in the literature. These include data from a number of states, including Rhode Island at an earlier time period when the entire process was considerably different in some significant ways, most notably the replacement of a "positive" formulary with the "negative."

In 1980, a publication of an earlier study conducted in Florida, a state with a negative formulary,[7] showed a substitution rate of 6.2 per cent and Mean Savings/Rx of $1.92. A federally funded study of DPS from 1976 to 1981 and published in the latter year identified a 7.6 per cent rate and $1.33 average saving in Michigan which has no formulary. A Rhode Island rate of 6.6 per cent with a positive formulary and $0.96 savings was found. Vermont's rate was 14.4 per cent with a positive formulary and $1.14 in average savings. Wisconsin with a positive formulary reportedly had a rate of substitution of 18.1 per cent and savings of $0.66.[8] In Illinois a state with a positive formulary[9] a study published in 1981 reported a 12.6 per cent rate and $1.47 average savings. In 1985, a Florida follow-up study showed a 6.8 per cent rate and $2.40 savings, not significantly better than the earlier results.[10]

The willingness of prescribers to authorize substitution as well as the frequency of prescriptions by generic name indicates a heightened awareness of the law and its provisions by prescribers and some growing confidence in its implementation.

Conclusions

Clearly, when the diagnosis and selected drug product for treatment are included among multisource choices, and the prescriber makes authorization known to the pharmacist, savings are possible to the consumer in Rhode Island. The magnitude of those savings is dependent on numerous factors which would serve as the basis for further study of the state's experience.

The conclusions are limited by the facts that the data were collected only during the month of November 1984 and were self-reported by pharmacists. A methodology utilizing a "rolling" data collection scheme might provide a leveling effect with seasonal adjustment for illness treatments throughout the year.

Notwithstanding these possible limitations, the data appear to support the conclusion that Drug Product Selection in Rhode Island is working to achieve the goals sought by the General Assembly in establishing the system. These goals have been met with no apparent impairment of the quality of health care provided to citizens of the state.

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Prediction of Ventricular Function From Plain Chest Roentgenogram

Cardiothoracic Ratio May Provide Valuable Information and Should be Measured

Tom J. Wachtel, MD
Rose Fredericks, MD

Chest roentgenograms are performed in everyday medical practice for "screening" or as part of the evaluation of the cardiovascular or pulmonary systems. Estimation of heart size is one of many reasons to perform this test. Previous studies have established a low correlation between the cardio-thoracic (CT) ratio on chest x-ray study and ejection fraction (EF) measured by quantitative bipline contrast angiographic data or radionuclide angiography.[1,2] The reliability of the chest x-ray films in predicting ventricular function is thus limited. However, these studies have repeatedly used an arbitrary cut-off of 0.5 for the CT ratio to separate cardiomegaly and "normal" heart size. In a recent study that examined the reliability of bedside evaluation in determining left ventricular function in a population of patients with suspected or proven coronary heart disease, the authors found cardiomegaly by chest x-ray study to be the best predictor of ejection fraction by radionuclide ventriculography (Pearson's correlation co-efficient $r = 0.52$).[3] The present study reexamines the correlation between chest x-ray study and ejection fraction by radionuclide angiography. Furthermore, with the use of nonparametric methods, we provide additional data that can be used to estimate ejection fraction from the CT radio by chest x-ray.

Methods

One hundred and twenty-five consecutive patients who were subjected to roentgenogram studies and radionuclide ventriculography for the evaluation of left ventricular function in our laboratory were retrospectively reviewed.

The radionuclide ventriculography was performed using a computerized multicrystal gamma camera (Baird-Atomic Systems 77) equipped with a one-inch parallel hole collimator position anterior to the precordium. The ejection fraction was measured by blood pool activity method, which as been shown to correlate well (Pearson's $r = 0.85$ to 0.93) with that measured by biplane contrast angiography.[4-6,8] We then reviewed the patients' x-ray files to find a standard six-foot anterior/posterior and lateral chest roentogenogram that had been performed within 30 days of the radionuclide ventriculography. Twenty-five cases did not satisfy this condition and were rejected from the study. We then measured the CT ratio as recommended by Felson on the film most nearly contemporary with the ventriculography.[7]

The next step consisted of a chart review. The presence of pericardial effusion was established by clinical signs and echocardiography (three cases were found and excluded). Similarly, a clinical diagnosis of cor pulmonale resulted in the exclusion of three cases. Any significant change in therapy susceptible of affecting the ejection fraction between the date of the roentgenogram and the centriculogram resulted in the exclusion of fifteen cases (administration, discontinuation, or change in dosage of diuretic drugs; digitalis; vasodilators; or beta blocking agents). The presence of valvular heart disease was established by clinical signs complemented by echocardiography or angiography, but did not result in exclusion. Seventy-five cases thus remained in the study for analysis. There were 41 men and 24 women whose ages ranged between 18 and 90 years (mean 65.9, S.D. 14.24).

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CT ratio / EF	< 0.50	0.54 to 0.50	≥ 0.55	Total
> 50%	16 (13)	10 (9)	6 (2)	32 (24)
30 to 50%	8 (7)	3 (3)	16 (13)	27 (23)
< 30%	0 (0)	5 (5)	11 (10)	16 (15)
Total	24 (20)	18 (17)	33 (25)	75 (62)

Table 1. Relationship of cardiothoracic ratio or chest x-ray with ejection fraction or radionuclide ventriculogram. X^2 4df = 23.7, $p < 0.005$. Numbers in parentheses are those cases left when valvular heart disease is excluded. (X^2 4df = 21.4, $p < 0.005$)

Results

The cases were divided into three arbitrary groups in terms of the ejection fraction: Group I — normal ejection fraction (>50%), Group II — mild to moderately reduced (30 to 50%), and Group III — severely reduced (<30%).

Group I included 32 cases, Group II 27 Cases, and Group III 16 cases. No patient in Group III had a CT ratio lower than 0.5. Only six patients in Group I had a CT ratio greater than 0.55. Of those six, four had significant valvular heart disease (two with mitral regurgitation and two with combined aortic and mitral regurgitation). Two were left for whom no satisfactory explanation for the discrepancy between CT ratio and radionuclide angiography could be extracted from the medical record. These findings were statistically significant (see Table I).

A CT ratio between 0.5 and 0.55 does not permit prediction of the ejection fraction. Similarly, mild to moderately reduced ejection fractions (Group II) cannot be predicted by CT ratio. The Pearson's correlation coefficient r between CT ratio and ejection fraction was −0.41 (Fig I). The F coefficient was 139, indicating high statistical significance ($p<0.001$). After exclusion of 13 cases with valvular heart disease, the correlation coefficient remained the same.

Discussion

As demonstrated by previous studies, a correlation between CT ratio on chest x-ray films and ejection fraction by radionuclide angiography exists, but is low.[1,3] When it is clinically important to monitor closely a patient's left ventricular function, the chest x-ray study is not accurate enough. An example of this would be the preoperative evaluation of a patient with a history of heart failure for cardiac surgery or a patient being treated with a cardiotoxic drug. Alternatively, clinical situations occur in daily practice when a crude estimate of left ventricular function is adequate. An example of this would be the use of a beta blocking agent in a patient with postinfarction angina.

The reporting of CT ratios by radiologists and clinicians has fallen into disfavor because of the relatively poor correlation with ventricular function. Our data suggest that the introduction of two cutoff points in the interpretation of heart size on chest x-ray films may improve the clinical usefulness of reporting relative heart size. Indeed a CT ratio of less than 0.5 has a high negative predictive value (100 per cent) because it reveals a low probability of severe reduction of ejection fraction (ie, <30 per cent), regardless of the presence of valvular heart disease. Con-

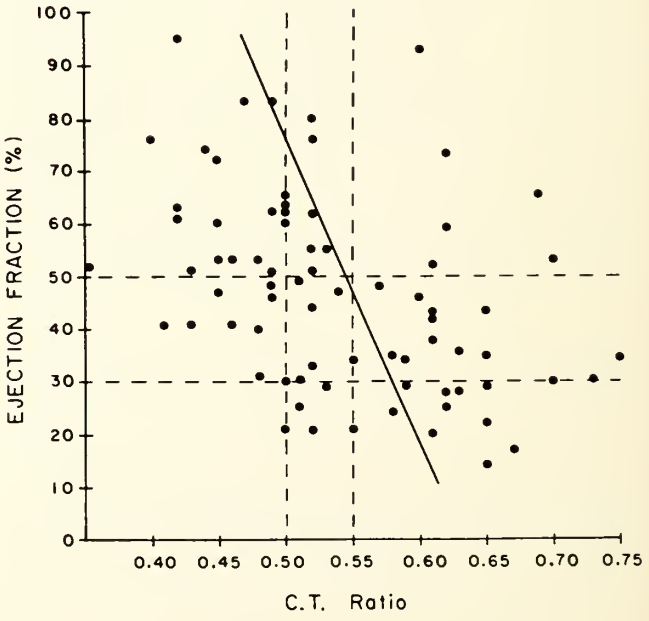


Fig I. Scattergram showing the distribution of CT ratio by ejection fraction. (Pearson's r = −0.41, F = 139, $p < 0.001$).

versely, a CT ratio of greater than 0.55 has a high positive predictive value (81 per cent) because it indicates a low probability of normal ejection fraction (ie, >50 per cent); when patients with valvular heart disease are excluded, the positive predictive value of a CT ratio greater than 0.55 is 92 per cent. CT ratios between 0.5 and 0.55 cannot predict ejection fraction and thus are not helpful. Based on our findings, CT ratios may provide valuable information for selected patients and should still be measured.

Summary

We studied 75 patients whose radionuclide angiography was contemporary with a standard six-foot postero/antero and lateral chest x-ray film. Patients with chronic lung disease, pericardial effusion, and unstable hemodynamic status were excluded.

The Pearson's correlation coefficient between cardiothoracic (CT) ratio and ejection fraction was 0.4 ($p<0.01$).

All patients with CT ratios lower than 0.5 had ejection fractions greater than 30 per cent. Only six patients with CT ratios greater than 0.55 had ejection fractions greater than 50 per cent. Four of these had regurgitant valvular disease. CT ratios between 0.5 and 0.55 could not predict ejection fraction. Similarly ejection fraction between 30 and 50 per cent could not be predicted by chest x-ray study.

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Rhode Island

ADVERSE DRUG REACTION
Reporting Project

SUSPECT A SERIOUS OR UNEXPECTED

ADVERSE DRUG REACTION?

Please Report It.

SUSPECTED ADVERSE REACTION REPORT (For All Drugs and Biologics)

IMPORTANT: SUBMISSION OF A REPORT DOES NOT NECESSARILY CONSTITUTE AN ADMISSION THAT THE DRUG CAUSED THE ADVERSE REACTION

PATIENT INITIALS (Optional)	AGE (Years)	SEX	DATE OF REACTION ONSET
A.D.R.	54	☑ MALE ☐ FEMALE	12 Oct. 1986

DESCRIBE REACTION(S) (Give signs, symptoms, diagnoses, course and lab findings)

JAUNDICE

CHECK ALL APPROPRIATE TO REACTION
- ☐ DIED
- ☑ TREATED WITH Rx DRUG
- ☑ INPATIENT HOSPITALIZATION
- ☐ SEVERE OR PERMANENT DISABILITY
- ☐ EMERGENCY ROOM TREATMENT
- ☐ TREATMENT IN PHYSICIAN OFFICE
- ☐ NONE OF THE ABOVE

SUSPECTED DRUG(S) (Trade Name is preferred. If a generic product, give manufacturer. Indicate Lot No. for vaccines, biologics)

[redacted]

REASON FOR USE OF DRUG(S)	ROUTE	TOTAL DAILY DOSE	DATES OF ADMINISTRATION
HYPERTENSION	P.O.	100mg.	9 Sept.- 12 Oct. '86

OTHER DRUGS TAKEN CONCOMITANTLY (Exclude those used to treat reaction)

None

OTHER RELEVANT HISTORY (e.g., Concomitant Diagnoses, Pregnancy, etc.)

None

PHYSICIAN NAME AND TELEPHONE NUMBER

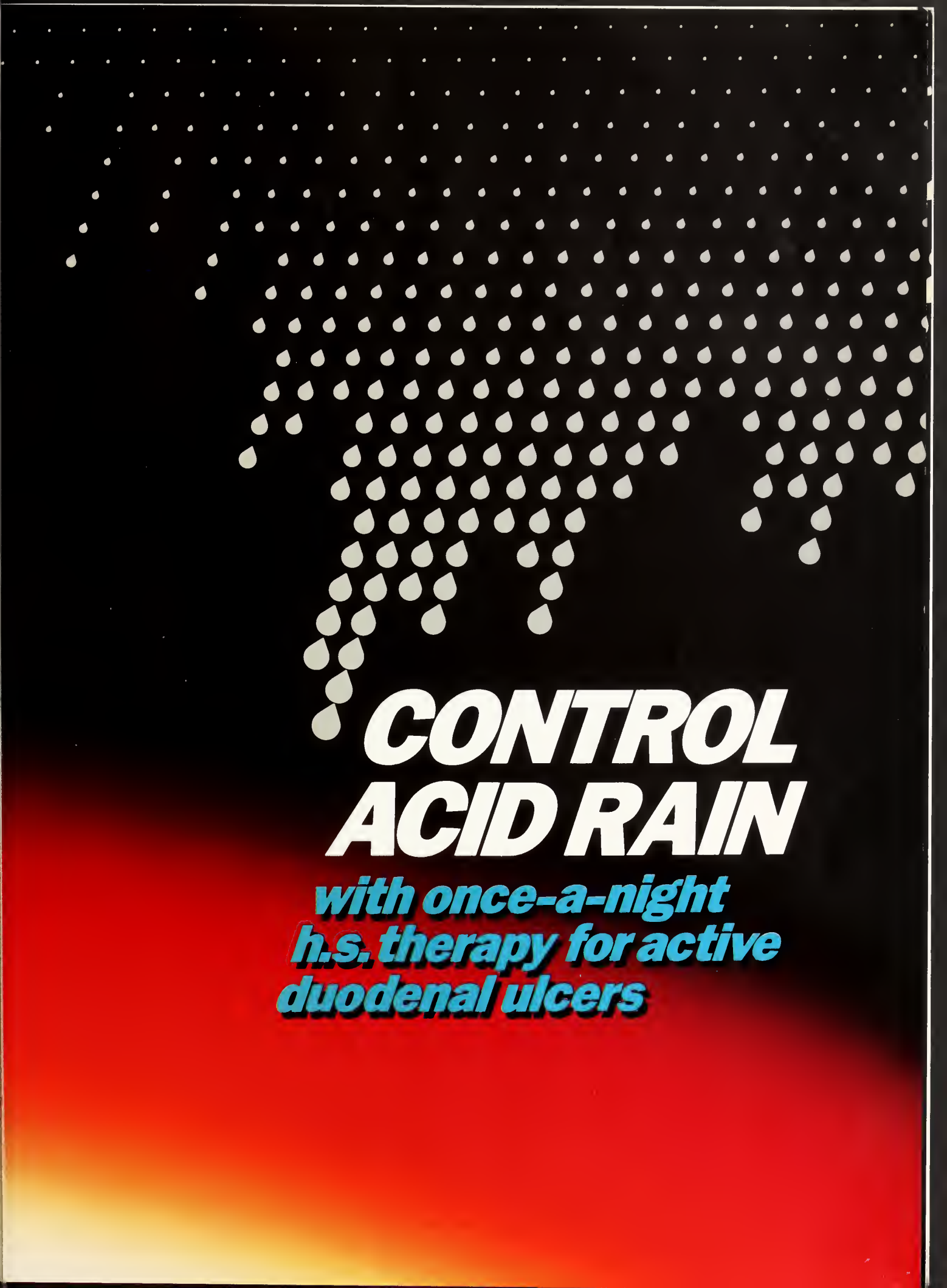
J. Doe, M.D. 277-2550

Confidential

ALSO REPORTED TO MANUFACTURER ☑ YES ☐ NO

For report cards, guidelines and information contact Dr. S. Rosenbaum, 277-2550

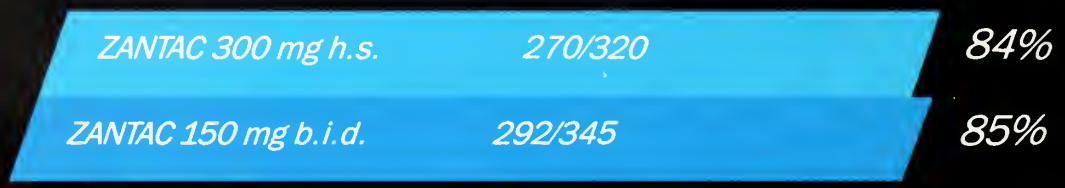
A pilot project of the Rhode Island Department of Health
sponsored by the U.S. Food and Drug Administration


CONTROL
ACID RAIN
with once-a-night
h.s. therapy for active
duodenal ulcers

Only one tablet at bedtime

Controls nocturnal acid to relieve pain and heal duodenal ulcers

Heals active duodenal ulcers after 4 weeks in most patients*[1]



In well-controlled, double-blind, multicenter trials, ZANTAC 300 mg h.s. healed active duodenal ulcers in 84% of patients after 4 weeks. After 8 weeks, healing rates may be higher with ZANTAC 150 mg b.i.d. (92%) than with ZANTAC 300 mg h.s. (87%).

Relieves pain and other symptoms as effectively as ZANTAC 150 mg b.i.d.[1]

Zantac® 300

ranitidine HCl/Glaxo 300 mg tablets

Once-daily dosing may enhance compliance in patients for whom dosing convenience is important

Side-effects profile comparable to ZANTAC 150 mg b.i.d.[1-3]

Headache—sometimes severe—has been reported. Rare effects on the CNS, cardiovascular, GI, hepatic, and integumental systems have been observed, as well as rare cases of hypersensitivity reactions. See ADVERSE REACTIONS section of Brief Summary of Product Information before prescribing.

No significant interference with the hepatic cytochrome P-450 enzyme system at recommended doses

ZANTAC 300 mg h.s. had no significant drug interactions with theophylline or warfarin. The bioavailability of certain medications whose absorption is dependent on a low gastric pH may be altered when ZANTAC or other medications which decrease gastric acidity are administered.



*It is not known exactly how much acid inhibition is needed to heal ulcers.

Glaxo / ROCHE

See next page for references and Brief Summary of Product Information.

IN ACTIVE DUODENAL ULCERS

Once-a-night h.s. therapy controls acid rain

Zantac® 300
ranitidine HCl/Glaxo 300 mg tablets

References: 1. Data available on request, Glaxo Inc. **2.** Ireland A, Colin-Jones OG, Gear P, et al: Ranitidine 150 mg twice daily vs 300 mg nightly in treatment of duodenal ulcers. *Lancet* 1984,2 274-275. **3.** Colin-Jones OG, Ireland A, Gear P, et al. Reducing overnight secretion of acid to heal duodenal ulcers. *Am J Med* 1984, 77 (suppl 5B) 116-122.

ZANTAC® 150 Tablets
(ranitidine hydrochloride)
ZANTAC® 300 Tablets
(ranitidine hydrochloride)

BRIEF SUMMARY OF PRODUCT INFORMATION

See complete product information before prescribing. The following is a brief summary.

INDICATIONS AND USAGE: ZANTAC® is indicated in:
1. Short-term treatment of **active duodenal ulcer**. Most patients heal within four weeks.
2. **Maintenance therapy** for duodenal ulcer patients at reduced dosage after healing of acute ulcers.
3. The treatment of **pathological hypersecretory conditions** (eg, Zollinger-Ellison syndrome and systemic mastocytosis).
4. Short term treatment of **active, benign gastric ulcer**. Most patients heal within six weeks and the usefulness of further treatment has not been demonstrated.
5. Treatment of **gastroesophageal reflux disease (GERD)**. Symptomatic relief commonly occurs within one or two weeks after starting therapy. Therapy for longer than six weeks has not been studied.

In active duodenal ulcer; active, benign gastric ulcer; hypersecretory states; and GERD, concomitant antacids should be given as needed for relief of pain.

CONTRAINDICATIONS: ZANTAC® is contraindicated for patients known to have hypersensitivity to the drug.

PRECAUTIONS: General: 1. Symptomatic response to ZANTAC® therapy does not preclude the presence of gastric malignancy. 2. Since ZANTAC is excreted primarily by the kidney, dosage should be adjusted in patients with impaired renal function. Caution should be observed in patients with hepatic dysfunction since ZANTAC is metabolized in the liver.

Laboratory Tests: False-positive tests for urine protein with Multistix® may occur during ZANTAC therapy, and therefore testing with sulfosalicylic acid is recommended.

Drug Interactions: Although ZANTAC has been reported to bind weakly to cytochrome P-450 in vitro, recommended doses of the drug do not inhibit the action of the cytochrome P-450-linked oxygenase enzymes in the liver. However, there have been isolated reports of drug interactions which suggest that ZANTAC may affect the bioavailability of certain drugs by some mechanism as yet unidentified (eg, a pH-dependent effect on absorption or a change in volume of distribution).

Carcinogenesis, Mutagenesis, Impairment of Fertility: There was no indication of tumorigenic or carcinogenic effects in lifespan studies in mice and rats at doses up to 2,000 mg/kg/day.

Ranitidine was not mutagenic in standard bacterial tests (*Salmonella, E coli*) for mutagenicity at concentrations up to the maximum recommended for these assays.

In a dominant lethal assay, a single oral dose of 1,000 mg/kg to male rats was without effect on the outcome of two matings per week for the next nine weeks.

Pregnancy: *Teratogenic Effects: Pregnancy Category B:* Reproduction studies have been performed in rats and rabbits at doses up to 160 times the human dose and have revealed no evidence of impaired fertility or harm to the fetus due to ZANTAC. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers: ZANTAC is secreted in human milk. Caution should be exercised when ZANTAC is administered to a nursing mother.

Pediatric Use: Safety and effectiveness in children have not been established.

Use in Elderly Patients: Ulcer healing rates in elderly patients (65 to 82 years of age) were no different from those in younger age groups. The incidence rates for adverse events and laboratory abnormalities were also not different from those seen in other age groups.

ADVERSE REACTIONS: The following have been reported as events in clinical trials or in the routine management of patients treated with oral ZANTAC®. The relationship to ZANTAC therapy has been unclear in many cases. Headache, sometimes severe, seems to be related to ZANTAC administration.

Central Nervous System: Rarely, malaise, dizziness, somnolence, insomnia, and vertigo. Rare cases of reversible mental confusion, agitation, depression, and hallucinations have been reported, predominantly in severely ill elderly patients.

Cardiovascular: Rare reports of tachycardia, bradycardia, and premature ventricular beats.

Gastrointestinal: Constipation, diarrhea, nausea/vomiting, and abdominal discomfort/pain.

Hepatic: In normal volunteers, SGPT values were increased to at least twice the pretreatment levels in 6 of 12 subjects receiving 100 mg qid IV for seven days, and in 4 of 24 subjects receiving 50 mg qid IV for five days. With oral administration there have been occasional reports of reversible hepatitis, hepatocellular or hepatocanalicular or mixed, with or without jaundice.

Musculoskeletal: Rare reports of arthralgias.

Hematologic: Rare reports of reversible leukopenia, granulocytopenia, thrombocytopenia, and pancytopenia.

Endocrine: Controlled studies in animals and man have shown no stimulation of any pituitary hormone by ZANTAC and no antiandrogenic activity, and cimetidine-induced gynecomastia and impotence in hypersecretory patients have resolved when ZANTAC has been substituted. However, occasional cases of gynecomastia, impotence, and loss of libido have been reported in male patients receiving ZANTAC, but the incidence did not differ from that in the general population.

Integumental: Rash, including rare cases suggestive of mild erythema multiforme, and, rarely, alopecia.

Other: Rare cases of hypersensitivity reactions (eg, bronchospasm, fever, rash, eosinophilia) and small increases in serum creatinine.

DOSAGE AND ADMINISTRATION: Active Duodenal Ulcer: The current recommended adult oral dosage is 150 mg twice daily. An alternate dosage of 300 mg once daily at bedtime can be used for patients in whom dosing convenience is important. The advantages of one treatment regimen compared to the other in a particular patient population have yet to be demonstrated.

Maintenance Therapy: The current recommended adult oral dosage is 150 mg at bedtime.

Pathological Hypersecretory Conditions (such as Zollinger-Ellison Syndrome): The current recommended adult oral dosage is 150 mg twice a day. In some patients it may be necessary to administer ZANTAC® 150-mg doses more frequently. Doses should be adjusted to individual patient needs, and should continue as long as clinically indicated. Doses up to 6 g/day have been employed in patients with severe disease.

Benign Gastric Ulcer: The current recommended adult oral dosage is 150 mg twice a day.

GERD: The current recommended adult oral dosage is 150 mg twice a day.

See full prescribing information for dosage adjustment for patients with impaired renal function.

HOW SUPPLIED: ZANTAC® 300 Tablets (ranitidine hydrochloride equivalent to 300 mg of ranitidine) are yellow, capsule-shaped tablets embossed with "ZANTAC 300" on one side and "Glaxo" on the other. They are available in bottles of 30 (NOC 0173-0393-40) and unit dose packs of 100 tablets (NOC 0173-0393-47).

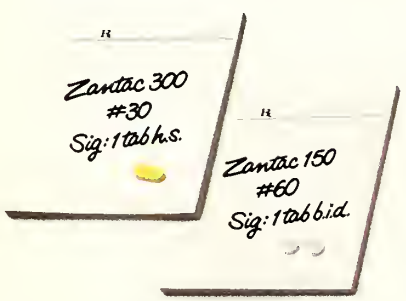
ZANTAC® 150 Tablets (ranitidine hydrochloride equivalent to 150 mg of ranitidine) are white tablets embossed with "ZANTAC 150" on one side and "Glaxo" on the other. They are available in bottles of 60 tablets (NOC 0173-0344-42) and unit dose packs of 100 tablets (NOC 0173-0344-47).

Store between 15° and 30°C (59° and 86°F) in a dry place. Protect from light. Replace cap securely after each opening.

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Glaxo
Glaxo Inc.
Research Triangle Park, NC 27709

Two effective regimens to treat active duodenal ulcers:



EXCERPTS FROM A SYMPOSIUM
"THE TREATMENT OF SLEEP DISORDERS"[8]

"...highly effective for both sleep induction and sleep maintenance"

Sleep Laboratory Investigator
Pennsylvania

"...onset of action is rapid...provides sleep with no rebound effect to agitate the patient the following day"

Psychiatrist
California

"...appears to have the best safety record of any of the benzodiazepines"

Psychiatrist
California

After 15 years, the experts still concur about the continuing value of Dalmane (flurazepam HCl/ Roche). It provides sleep that satisfies patients... and the wide margin of safety that satisfies you.

The recommended dose in elderly or debilitated patients is 15 mg. Contraindicated in pregnancy.

DALMANE®

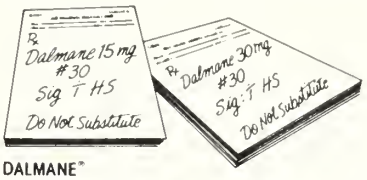
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flurazepam HCl/Roche Ⓒ Ⓥ

sleep that satisfies

15-mg/30-mg capsules



References: **1.** Kales J, *et al Clin Pharmacol Ther 12* 691-697, Jul-Aug 1971 **2.** Kales A, *et al Clin Pharmacol Ther 18*:356-363, Sep 1975 **3.** Kales A, *et al. Clin Pharmacol Ther 19* 576-583, May 1976 **4.** Kales A, *et al Clin Pharmacol Ther 32*:781-788, Dec 1982 **5.** Frost JD Jr, DeLucchi MR *J Am Geriatr Soc 27* 541-546, Dec 1979 **6.** Dement WC, *et al: Behav Med*, pp. 25-31, Oct 1978 **7.** Kales A, Kales JD *J Clin Psychopharmacol 3* 140-150, Apr 1983 **8.** Tennont FS, *et al* Symposium on the Treotment of Sleep Disorders, Teleconference, Oct 16, 1984. **9.** Greenblatt DJ, Allen MD, Shader RI. *Clin Pharmacol Ther 21* 355-361, Mar 1977



DALMANE®
brand of
flurazepam HCl/Roche Ⓒ Ⓥ

Before prescribing, pleose consult complete product informotion, o summory of which follows:

Indicotions: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnol awakenings ond/or early morning awakening, in patients with recurring insomnia or poor sleeping habits, in acute or chronic medical situotions requiring restful sleep Objective sleep laboratory dato have shown effectiveness for at leost 28 consecutive nights of administrotion Since insomnio is often transient ond intermittent, prolonged administrotion is generally not necessary or recommended Repeated therapy should only be undertaken with oppropriate patient evaluation

Controindicotions: Known hypersensitivity to flurazepam HCl, pregnoncy Benzodiazepines may cause fetal damage when administered during pregnoncy Severol studies suggest an increased risk of congenifal malformations associated with benzodiazepine use during the first trimester Worn patients of the potenfiol risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam Instruct potients to discontinue drug prior to becoming pregnant Consider the possibility of pregnoncy prior to instituting therapy

Wornings: Caution patients about possible combined effects with olcohol and other CNS depressonts An odditive effect may occur if alcohol is consumed the day following use for nighttime sedation This potential may exist for several days following discontinuation Caution ogainst hozordous occupations requiring complete mental alertness (*e g* , operating machinery, driving) Potential impairment of performance of such activities may occur the day following ingestion Not recommended for use in persons under 15 yeors of age Withdrawal symptoms rarely reported, abrupt-discontinuation should be avoided with graduol tapering of dosage for those patients on medicotion for o prolonged period of time Use caution in administering to addiction-prone individuals or those who might increase dosage

Precoutions: In elderly and debilitoted patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedotion, dizziness, confusion ond/or otoxia Consider potentiol odditive effects with other hypnotics or CNS depressants Employ usual precoutions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impoired renal or hepotic function

Adverse Reoctions: Dizziness, drowsiness, lightheadedness, stoggering, ataxia and falling have occurred, particularly in elderly or debilitoted potients Severe sedotion, lethargy, disorientation ond como, probably indicative of drug intolerance or overdosage, have been reported Also reported headache, heortburn, upset stomach, nauseo, vomiting, diorrhea, constipation, GI poin, nervousness, tolkotiveness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains ond GU complaints There hove also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breoth, pruritus, skin rash, dry mouth, bitter toste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hollucinations, and elevoted SGOT, SGPT, total and direct bilirubins, ond alkaline phosphatase, and paradoxical reactions, *e g* excitement, stimulation and hyperactivity

Dosoge: Individualize for maximum beneficial effect *Adults* 30 mg usuol dosage, 15 mg moy suffice in some patients *Elderly or debilitated patients* 15 mg recommended initially until response is determined

Supplied: Copsules containing 15 mg or 30 mg flurozepam HCl

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Manoti, Puerto Rico 00701

#1 FOR SLEEP

After more than 15 years of use, it's #1 for sleep that satisfies. Patients are satisfied because they fall asleep fast and stay asleep till morning.[1-8] And *you're* satisfied by the exceptionally wide margin of safety.[7-9] As always, caution patients about driving or drinking alcohol.

Please see adjacent page for references and summary of product information.

DALMANE®

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sleep that satisfies



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